

Research Only

19DHR01959

Optima Family Care of North Carolina Inc

v.

North Carolina Department of Health and Human Services Mandy Cohen MD MPH in her ofc capacity as
Sec of the Dept and Dave Richard in his ofc capacity as Deputy Sec of the Dept of NC Medicaid

DOCKET NO. 19DHR01959
Optima Family Care of North Carolina Inc
vs

North Carolina Department of Health and Human Services Mandy Cohen MD MPH in her ofc
capacity as Sec of the Dept and Dave Richard in his ofc capacity as Deputy Sec of the Dept
of NC Medicaid

Research Only

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STATE OF NORTH CAROLINA COUNTY OF WAKE	IN THE OFFICE OF ADMINISTRATIVE HEARINGS
<p>Optima Family Care of North Carolina, Inc., Petitioner,</p> <p>v.</p> <p>North Carolina Department of Health and Human Services, Mandy Cohen, M.D., MPH, in her official capacity as Secretary of the Department, and Dave Richard in his official capacity as Deputy Secretary of the Department for NC Medicaid, Respondent,</p> <p>And</p> <p>WellCare of North Carolina, Inc., Blue Cross And Blue Shield of North Carolina, AmeriHealth Caritas of North Carolina, Inc., UnitedHealthCare of North Carolina, Inc., and Carolina Complete Health, Inc., Respondent-Intervenors.</p>	19 DHR 01959
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exaggerates these facts, apparently motivated by desperation and an effort to create sensationalistic headlines to place public pressure on the Department. In reality, Aetna has offered no meaningful reason or excuse for its negligent failure to recognize the key facts about the RFP scoring until this late date.

After extensive discovery—including sworn deposition testimony from sixteen different Department employees taken over more than twenty days and the production of more than two hundred thousand pages of documents—Aetna has likely realized that its original arguments are doomed to failure. In a desperate bid to overturn the Department’s decision, Aetna now seeks to file a new complaint that presents wild conspiracy theories, not facts. Aetna seeks to impugn the integrity of both employees of the Department and employees of Blue Cross NC through innuendo and personal attack, but Aetna has not identified any actual conflicts of interest, let alone improper decisions or actions by the Committee or its members.

Aetna’s desperation is evident. It now faults the Department for conducting a quality assurance process prior to making a final recommendation. The Department understandably took this step to ensure that the final scores were accurate and consistent—a reasonable step after a lengthy evaluation period that involved scoring dozens of questions for eight offerors. Notably, Aetna has little, if anything, to say about the substantive changes that were made during the quality assurance process. Instead, Aetna’s arguments amount to a complaint that the quality assurance process must have been improper because it was unfavorable to Aetna. This self-serving argument is baseless and, ultimately, futile.

Procedural History

The Department announced the award winners in this RFP on February 4, 2019. Just days later, the Department began to produce documents in response to public records requests about the

RFP. These documents included copies of the Evaluation Committee Meeting Notes & Timeline, as well as the detailed spreadsheet that identified the scores for each offeror on each question.

Aetna submitted its protest letter to the Department on March 5, 2019. After a protest meeting on March 27, 2019, the Department denied Aetna's protest on April 12, 2019. Aetna then submitted its contested case petition in this Tribunal on April 16, 2019. In both its protest letter and its contested case petition, Aetna focused on three general issues. First, Aetna contended that it should have received more points for its responses to certain questions. Aetna Protest Letter at 2; Aetna Pet. ¶ 120.¹ Second, Aetna contended that AmeriHealth Caritas ("AmeriHealth") should have received fewer points for their responses. Aetna Protest Letter at 2; Aetna Pet. ¶ 120. Finally, Aetna argued that WellCare of North Carolina, Inc. ("WellCare") should have been disqualified. Aetna Protest Letter at 2; Aetna Pet. ¶ 120. Notably, Aetna did not challenge any points awarded to Blue Cross NC or suggest any conflicts of interest among Department employees.

On the same day that Aetna filed its petition, Aetna also filed a motion seeking a preliminary injunction. The Tribunal denied Aetna's motion for a preliminary injunction on June 26, 2019, reasoning that Aetna had failed to demonstrate the requisite likelihood of success on the merits.

The operative scheduling order at the time that Aetna filed its motion called for discovery to close on September 30, with dispositive motions due on October 18, 2019. August 23, 2019 Scheduling Order at 3.² To date, the parties have taken sworn deposition testimony from sixteen

¹ Aetna's Protest Letter is Exhibit A to Aetna's original, and operative, petition.

² The Tribunal subsequently issued an order extending the deadline for the completion of discovery to today, October 4, 2019. September 26, 2019 Memorandum of Discovery Conference and Order. The dispositive motions deadline remains October 18, 2019.

Department witnesses, with many of those witnesses appearing on multiple days. The Department has also produced more than 200,000 pages of documents.

Standard of Review

While leave to amend “shall be freely given when justice so requires,” N.C. Gen. Stat. § 1A-1, Rule 15(a); 26 NCAC 03 .0101(a), denial of an amendment is justified in instances of “(a) undue delay, (b) bad faith, (c) undue prejudice, (d) futility of amendment, and (e) repeated failure to cure defects by previous amendments.” *Providence Volunteer Fire Dep’t v. Town of Weddington*, ___ N.C. App. ___, ___, 800 S.E.2d 425, 431 (2017); *see also Azure Dolphin, LLC v. Barton*, ___ N.C. ___, ___, 821 S.E.2d 711, 728 (2018). Such motions are entrusted to the sound discretion of the trial judge. *Rabon v. Hopkins*, 208 N.C. App. 351, 353, 703 S.E.2d 181, 184 (2010).

Argument

I. Aetna’s Motion is Untimely and Unduly Prejudicial

A. The Motion is Untimely

Aetna’s motion to amend its petition is untimely. In determining whether there has been undue delay, the court “may consider the relative timing of the proposed amendment in relation to the progress of the lawsuit.” *Wilkerson v. Duke Univ.*, 229 N.C. App. 670, 679, 748 S.E.2d 154, 161 (2013). Where the party seeking an untimely amendment knows or should have known of the facts upon which the proposed amendment is based, but fails to assert them in a timely fashion, the motion to amend is subject to denial. *See Media Network, Inc. v. Long Haymes Carr, Inc.*, 197 N.C. App. 433, 447–48, 678 S.E.2d 671, 681 (2009) (affirming denial of leave to amend where—despite knowing the relevant facts and failing to raise them in their original pleadings—defendants filed motion to amend three months after filing answer and offered no credible explanation for the

delay); *see also Tenneco Resins, Inc. v. Reeves Bros., Inc.*, 752 F.2d 630, 634 (Fed. Cir. 1985) (“A litigant’s failure to assert a claim as soon as he could have is properly a factor to be considered in deciding whether to grant leave to amend.”).

Aetna argues that its motion to amend should be granted because of its “recent discovery of new facts.” Motion at 3. Aetna principally contends that it “recently learned *for the first time*” that the RFP Evaluation Committee had—at one point in the evaluation process—ranked Aetna among the top four offerors. *Id.* (emphasis in original). Aetna goes on to claim that the documents originally produced by the Department in February 2019 in response to public records requests “never make[] any mention of the original scoring in which Aetna was in the top four Offerors.” *Id.* at 4.

Aetna is wrong. The purportedly “new facts” that Aetna identifies in its motion were readily apparent in the documents that the Department produced in February. Aetna provides no justification for its belated attempt to change the nature of this contested case at this late date. After months of discovery, Aetna has apparently realized the futility of the arguments it has thus far presented to the Department and this Tribunal. Now, in a last-ditch, desperate effort, Aetna is seeking to reorient its arguments around exaggerated facts that have been obvious for months. There is no excuse for this bait-and-switch; the Tribunal should deny Aetna’s belated request.

The final score for each bidder was indisputably made public. Indeed, the relative closeness of the scores for the top five bidders was a central element of Aetna’s original petition. Aetna Pet. ¶ 29. Aetna was well aware that it scored approximately 2 points lower than United and 7.5 points lower than Blue Cross NC. This was made clear in the “PHP Evaluation Committee Meeting Notes and Timeline” (Exhibit A, “Meeting Notes & Timeline”) that the Department

released in February 2019, shortly after the contract awards were announced publicly on February 4, 2019. Exhibit A, Meeting Notes & Timeline at 23; Aetna Pet. ¶ 29.

The Meeting Notes & Timeline provide detailed information about the Evaluation Committee's activities between October 2018 and February 2019. Notably, the notes reflect that the Evaluation Committee on December 19, 2018, declined to count a reference identified in the Blue Cross NC RFP response after discussing it that day and on the previous day. Exhibit A, Meeting Notes & Timeline at 13-14.³

The meeting notes also show that the Department understandably did "several quality assurance reviews" after the initial scoring was completed "to ensure consistency and accuracy of the score[s]." Exhibit A, Meeting Notes & Timeline at 18. The January 18, 2019 notes reflect that "[t]he next step of the quality assurance process is for [Department counsel] Lotta Crabtree to review the scoring of Offeror Client References." *Id.* at 21. The meeting notes reflect that, at the next meeting on January 22, 2019, the Evaluation Committee heard from Ms. Crabtree and determined that it should count the South Carolina reference for Blue Cross NC. *Id.* at 21. The meeting notes clearly state that "the scoring was updated accordingly." *Id.*

It was readily apparent from the documents released publicly in February that the January 22, 2019 decision to count the South Carolina reference added 12.5 points to Blue Cross NC's score. The documents that the Department released immediately after the awards were announced on February 4, 2019 made it obvious that each client reference was worth up to 12.5 points, and that Blue Cross NC's score would have increased by 12.5 points when the Evaluation Committee

³ The reference was from BlueChoice Health Plan of South Carolina for Amerigroup Partnership Plan, LLC ("Amerigroup"). Blue Cross NC's RFP response identified Amerigroup as its strategic collaborator in providing Medicaid managed care in North Carolina. The reference is henceforth referred to as the "South Carolina reference."

decided that it should count the South Carolina reference on January 22. Specifically, the scoring summary chart showed that the references were worth up to 50 points, and that Blue Cross NC had received 25 points for its references. *See* PHP Consensus Scoring Excel File at 3 (Exhibit B). The detailed chart providing the scores for Blue Cross NC's response confirms that it received 12.5 points for the South Carolina reference and 12.5 for another reference that was counted by the committee. (Two other references were not returned and, therefore, were not scored). *Id.* at 54.

It was, therefore, obvious from the documents that Blue Cross NC received 12.5 points when the Evaluation Committee determined that it should score the South Carolina reference on January 22, 2019 as part of its quality assurance review to determine that the scoring was appropriate and consistent for all offerors. The Evaluation Committee proceeded to make its award determination later that day, and the Meeting Notes and Timeline makes clear that the Evaluation Committee did not make any other decisions that affected scoring on January 22, 2019. Exhibit A, Meeting Notes & Timeline at 22-23.

Thus, given the final scores, it was obvious that Aetna moved from fourth place to fifth place on January 22, 2019. To the extent that Aetna was surprised by deposition testimony and documents confirming that the relative position of offerors changed on January 22, 2019, that is a problem of Aetna's own making. It was obvious from the documents that the Department made available in February, 2019, more than seven months ago.⁴

⁴ Notably, Aetna is vague about when it realized that the offerors' relative positions shifted. Aetna's motion refers to the Department's production of a document on September 4, 2019. Motion at 4. But Aetna carefully avoids saying that it learned of this issue on September 4. Indeed, Ms. Kilpatrick specifically testified about this issue as early as August 27. Kilpatrick Dep. Vol. IV (Exhibit C) at 680-682. This means that Aetna, at a minimum, should have been aware of this issue for more than three weeks before it filed its motion to amend—even if Aetna had failed to recognize this issue in its review of publicly available documents.

B. Granting the Motion would Prejudice Blue Cross NC

Aetna's belated filing at the end of discovery in this contested case has the potential to cause substantial harm to Blue Cross NC. It is well-established that such late-stage motions, particularly those which raise factual allegations that the party seeking to amend already knew or should have known, are likely to cause prejudice. *See Golden Rule Ins. Co. v. Long*, 113 N.C. App. 187, 200, 439 S.E.2d 599, 606 (1993) (affirming denial of motion to amend after "extensive discovery" and plaintiff's "delay was undue"); *see also Stetser v. TAP Pharm. Prods. Inc.*, 165 N.C. App. 1, 31, 598 S.E.2d 570, 590 (2004) (affirming denial of motion to amend that "could involve more discovery for the parties, slow the litigation process, and present a more unwieldy litigation for the trial court to administrate"); *Everett v. Duke Energy Carolinas, LLC*, 2018 WL 5796351 (N.C. Ct. App. 2018) (unpublished) (affirming denial of motion to amend made "several months after the beginning of discovery").

Here, Aetna put forward its new arguments and theories after virtually all of the relevant witnesses had been deposed and just days before the close of document discovery. Indeed, discovery in this matter currently closes today, October 4, 2019, meaning that this Tribunal's ruling on Aetna's motion will not come until after the close of discovery. Mem. Discovery Conf. and Order at 3. Accordingly, if Aetna is permitted to file its proposed amended petition, Blue Cross NC will be unable to conduct further discovery into Aetna's new, baseless factual theories, particularly in light of the current October 18, 2019 deadline for filing dispositive motions. The Tribunal should not reward this gamesmanship so late in the discovery process.

II. Aetna's Motion is Futile

Aetna's proposed amended complaint is also futile for two reasons. First, Aetna's proposed amended petition could not meet the high standard needed for recovery, and second, Aetna has failed to exhaust its administrative remedies.

A. Aetna's New Theories are Legally Insufficient and Factually Incorrect.

The Tribunal has already recognized that Aetna can only prevail upon a showing of "bad faith, lack of fair and careful consideration, or lack of any course of reasoning and exercise of judgment." Aetna Prelim. Inj. Order at ¶ 49. Aetna cannot meet this high standard under its operative petition, nor may it do so under its proposed amended petition. This renders its proposed amended petition futile. *N.C. Council of Churches v. State*, 120 N.C. App. 84, 94, 461 S.E.2d 354, 360 (1995).

At this point, sixteen Department witnesses have testified under oath in lengthy depositions and the Department has produced more than two hundred thousand pages of documents. With nothing to support Aetna's technical scoring challenges, Aetna now resorts to a smear campaign that seeks to impugn the integrity of Department employees and Blue Cross NC through insinuation and wild conspiracy theories. Aetna's desperation is evident, and its insinuations are easily debunked. In reality, Aetna's proposed amended petition is futile.

Aetna alleges that there was a "conflict[] of interest" because Evaluation Committee member Amanda Van Vleet's boyfriend works at Blue Cross NC and his job has the word "Transformation" in the title. Proposed Amended Pet. ¶¶ 35(a), 36, 148. Ms. Van Vleet disclosed this relationship to Jay Ludlam, Assistant Secretary for Medicaid, when she was being interviewed to work at the Department and her potential role on the Evaluation Committee was discussed. Van Vleet Dep. (Exhibit D) 115:10-116:7. She also disclosed it to Kimberley Kilpatrick, the contracts

specialist who worked with the Evaluation Committee, early in the evaluation process. *Id.* 117:12-25.

Ms. Van Vleet has already testified under oath that her boyfriend did not have direct responsibility for Medicaid projects and that she believed that she could evaluate the RFP responses objectively and fairly. Exhibit D, Van Vleet Dep. 120:22-121:4; Inman Aff. (Exhibit E) ¶ 12. She also testified that she sought to minimize even the potential for even an appearance of a conflict of interest, including, for example, making a “conscious effort to not see or meet anyone that [her boyfriend] worked with during [the evaluation] process.” *Id.* at 122:20-123:2.

At bottom, there is no evidence whatsoever that Ms. Van Vleet’s relationship had any impact on the RFP evaluation process. Instead, Aetna apparently hopes that innuendo and baseless conspiracy-mongering will win the day.

Aetna also implies that there is something improper about Evaluation Committee member Sheila Platts leaving the Department to work for Blue Cross NC in July of 2019. But Ms. Platts’ testimony was unequivocal and undisputed: Ms. Platts merely responded to a public job listing months after the RFP decisions were announced and was hired into a job where she does no work on Medicaid projects. Platts Dep. (Exhibit F) 15:4-13, 137:4-21; Exhibit E, Inman Aff. ¶ 8. Aetna unjustly attacks Ms. Platts personally by alluding to her recent filing for personal bankruptcy, invading her personal privacy and seeking to muddy the waters by innuendo and unfair implication. Proposed Amended Pet. ¶¶ 35(b), 148.

Again, Aetna has not identified any actual conflict of interest or way in which Ms. Platts’ post-award decision to change jobs could have possibly affected the RFP process—let alone that it actually did affect the process. Aetna evidently hopes that unfounded implications and veiled personal attacks will be sufficient. The Tribunal should not reward this underhanded strategy.

Aetna’s remaining attacks on the Department’s and Blue Cross NC’s employees are even more desperate. Aetna suggests impropriety based on the fact that a non-scoring member of the Evaluation Committee, Sarah Gregosky, previously worked for Blue Cross NC. Proposed Amended Pet. ¶¶ 35(c), 148.⁵ Aetna also appears to complain that a scoring member worked for Blue Cross Blue Shield of South Carolina.⁶ *Id.* ¶ 35(c). But the existence of prior employment relationships with offerors is unsurprising and unproblematic. Indeed, the Assistant Secretary for North Carolina Medicaid formerly worked for Aetna and WellCare. Dep. Ex. 303 (Exhibit G). Another scoring member worked for Centene (one of the key partners in offer Carolina Complete Health). Doyle Dep. (Exhibit H) 21:3-21. These prior relationships are unobjectionable—skilled and knowledgeable employees are likely to have some experience in the private health care sector.⁷

Aetna’s final allegation is even further afield. Specifically, Aetna suggests that there was impropriety because two non-scoring members of the Evaluation Committee previously worked for the State Health Plan, which is administered by Blue Cross NC. These employees did not work

⁵ Aetna misspells Ms. Gregosky’s name as “Gregowski.”

⁶ In paragraph 35(c), of the Proposed Amended Petition, Aetna alleges that an Evaluation Committee member who scored the bids “had previously been employed by BCBS.” Aetna appears to be referring to the fact that Ms. Platts was employed by Blue Cross and Blue Shield of South Carolina (“Blue Cross SC”) fourteen years ago. Blue Cross SC is a completely separate and independent, locally-operated company in South Carolina. See <https://www.bcbs.com/bcbs-companies-and-licensees>.

Notably, Aetna appears to have changed its naming conventions in an effort to sow confusion and imply impropriety. In its original Petition, Aetna defined Intervenor Blue Cross NC as “BCBSNC.” Aetna Pet. ¶ 27 (identifying Blue Cross NC as “BCBSNC”); *see also id.* at ¶¶ 28, 29, 47, 64, 88, 123. But now, in its proposed amended petition, Aetna uses “BCBS” throughout, presumably to confuse Blue Cross NC with Blue Cross SC and erroneously imply that the companies are related. Aetna Amended Pet. ¶ 1 (identifying Blue Cross NC as “BCBS”); *see also generally* Aetna Amended Pet.

⁷ In fact, Aetna’s own employment practices show the frequent overlap between the Department and North Carolina insurers. Jamal Jones, Aetna’s Director of Business Development for Medicaid—and a frequent client representative for the depositions in this matter—worked for the Department prior to joining Aetna. Dep. Ex. 425 (Exhibit I).

for Blue Cross NC—to the contrary, at all times they worked for the State. The suggestion that their prior work for the State Health Plan created a conflict of interest is simply bizarre.

Nothing in Aetna’s proposed amended complaint rises to the level required to overturn the Department’s contracting decision. Instead, the proposed complaint simply reflects Aetna’s desperation and hope that it can muddy the water through false innuendo and unjustified personal attacks on the Department’s and Blue Cross NC’s employees.

B. Aetna Failed To Exhaust Its New Claims

Aetna’s motion to amend should be denied for the independent reason that it failed to exhaust its new claims in a protest to the Department. “A plaintiff’s failure to exhaust administrative remedies may result in the dismissal of the complaint for lack of subject-matter jurisdiction.” *Abrons Family Practice & Urgent Care, PA v. N. C. Dep’t of Health & Human Servs.*, 370 N.C. 443, 447, 810 S.E.2d 224, 228 (2018). North Carolina law and the RFP are clear that all protests must first be directed to the agency charged with decision-making in an RFP. *See* RFP § II.G.6; 01 NCAC 05B .1519. “The requirement to exhaust administrative remedies ensures that ‘matters of regulation and control are first addressed by commissions or agencies particularly qualified for the purpose.’” *Id.* at 450, 810 S.E.2d at 230 (quoting *Presnell v. Pell*, 298 N.C. 715, 722, 260 S.E.2d 611, 615 (1979)).

Here, Aetna has not presented any of its arguments about scoring changes and alleged conflicts of interest to the Department. The only arguments that Aetna presented to the Department are that Aetna should have been awarded more points for its responses to certain questions, that AmeriHealth should have been awarded fewer points for its responses, and that WellCare should have been disqualified. Aetna Protest Letter at 2. The Department responded to those arguments and, as noted above, extensive discovery has yielded no reason to doubt the Department’s decision-

making on these issues, let alone overturn the Department's decision. Aetna has presumably realized its initial arguments about the Department's substantive decisions are baseless, so Aetna is now trying to change theories by casting doubt on the scoring process—both in this Tribunal and in the press.

Aetna is prohibited from making new, alternative arguments to this Tribunal when it has failed to present those arguments to the Department in the first instance. Here, “the legislature has expressed an intention to give the administrative entity most concerned with a particular matter”—the Department—“the first chance to discover and rectify error.” *Presnell*, 298 N.C. at 721, 260 S.E.2d at 615. Only after the Department “has developed its own record and factual background upon which its decision must rest should the courts be available to review the sufficiency of its process.” *Id.* at 721-722, 260 S.E.2d at 615. To allow otherwise would undermine legislative intent and permit Aetna and other protestors to present new and different arguments attacking the RFP decision at any point without giving the Department the opportunity to address those arguments in detail at the outset. It is hard to conceive of a more classic situation in which the Department should have a full opportunity to respond in the first instance than factual allegations of the type that Aetna raises here, which go to the Department's process for reviewing RFP responses and the integrity of its employees. The administrative exhaustion requirement is specifically intended to prevent such belated efforts to disrupt the effective functioning of administrative agencies.

Conclusion

For the foregoing reasons, Aetna's motion should be denied.

This the 4th day of October, 2019.

/s/ Jennifer K. Van Zant

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CERTIFICATE OF SERVICE

I hereby certify that on this date I caused to be served the foregoing by electronic service through electronic filing with the Office of Administrative Hearings, as defined in 26 N.C.A.C. 03 .0501(4), and by electronic mail on those listed below:

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This the 4th day of October, 2019.

/s/ Jessica Thaller-Moran
Jessica Thaller-Moran

STATE OF NORTH CAROLINA COUNTY OF WAKE	IN THE OFFICE OF ADMINISTRATIVE HEARINGS
<p>Optima Family Care of North Carolina, Inc., Petitioner, v. North Carolina Department of Health and Human Services, Mandy Cohen, M.D., MPH, in her official capacity as Secretary of the Department, and Dave Richard in his official capacity as Deputy Secretary of the Department for NC Medicaid, Respondent,</p> <p>And</p> <p>WellCare of North Carolina, Inc., Blue Cross And Blue Shield of North Carolina, AmeriHealth Caritas of North Carolina, Inc., UnitedHealthCare of North Carolina, Inc., and Carolina Complete Health, Inc., Respondent-Intervenors.</p>	19 DHR 01959
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<p>Aetna Better Health of North Carolina, Inc., d/b/a Aetna Better Health of North Carolina, Petitioner,</p> <p style="text-align: center;">v.</p> <p>State Of North Carolina Department of Health and Human Services - Division of Health Benefits, Respondent,</p> <p style="text-align: center;">And</p> <p>WellCare of North Carolina, Inc., Blue Cross And Blue Shield of North Carolina, AmeriHealth Caritas of North Carolina, Inc., UnitedHealthCare of North Carolina, Inc., Carolina Complete Health, Inc., Respondent-Intervenors.</p>	<p>19 DHR 02194</p>
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EXHIBIT A

Attachment #4 PHP Evaluation Committee Meeting Notes and Timeline

October 17, 2018, 10:00 AM – 12:00 PM

Kick Off Meeting for Evaluation Committee.

Attendees and Roles:

Scoring Members:	Non-Scoring Contract Leads	Non-Scoring Subject Matter Expert (SME)	Non-Scoring Legal Counsel	Non-Scoring Leadership
Tabitha Bryant Melanie Bush Patrick Doyle Sabrena Lea Catherine Pace Sheila Platts Amanda Van Vleet	Kimberly Kilpatrick Gregory Sligh	Sarah Gregosky	Lotta Crabtree	Jay Ludlam Mona Moon

1. See *Attachment #3 PHP Evaluation Kick-Off Meeting – Scoring Members* for the meeting presentation.
2. The Contract Leads conducted the Kick-Off Meeting. Items discussed included:
 - a. Ensuring and maintaining the integrity of the procurement process.
 - b. Confidentiality and Conflict of Interest Statements (Statements).
 - c. Location and process to access evaluation materials on SharePoint upon completion of the Statements.
 - d. Hardcopies of proposals also available in evaluation meeting room but must not leave the McBryde building
 - e. Evaluation ground rules.
 - f. Time commitment.
 - g. Notetaking. The attendees were advised that notes, if any, will be taken up during the evaluation and become part of the solicitation file.
 - h. Consensus scoring will be used. The Scoring Members will review and discuss the responses, determine if they need guidance from a SME or a Clarification to any Offeror's response, and work to reach consensus on the final score for each evaluation question.
 - i. Blocks of time will be scheduled, and specific sections to be discussed and scored will be communicated in advance of each meeting.
 - j. SMEs to be notified and scheduled in advance of scoring specific sections to provide any information requested prior to scoring a section.
 - k. Discussed the 5 Level Rating Scale Definitions. The baseline for scoring, where applicable, is that each response Meets Expectations. If the Committee

determines the response reflects something different, information supporting the rationale for assigning a different score will be documented. Discussed that some questions will have other criteria to score based on the type of question and information to be provided.

- I. The Evaluation Committee was taken to McBryde West Room 106 where the evaluation will be conducted.
3. Upon completion of the Confidentiality and Conflict of Interest Statements, Committee members were provided access to the *RFP 30-190029-DHB PHP Eval* folder on SharePoint.

October 23 and October 24, 2018

Kick-Off Meetings for Subject Matter Experts were held on October 23, 2018 2:00 – 3:00 PM and October 24, 10:00 – 11:00 AM.

1. See *Attachment #5 PHP Evaluation Kick-Off Meeting – SMEs* for the meeting presentation.
2. The Contract Leads conducted the Kick-Off Meeting. Items discussed included:
 - a. Initial SMEs identified for specific evaluation areas; others may be added.
 - b. Ensuring and maintaining the integrity of the procurement process.
 - c. Confidentiality and Conflict of Interest Statements (Statements).
 - d. Location and process to access evaluation materials on SharePoint upon completion of the Statements.
 - e. Hardcopies of proposals will be made available upon request but must not leave the McBryde building.
 - f. Time commitment and being prepared to support the Evaluation Committee.
 - g. Notetaking. The attendees were advised that notes, if any, will be taken up during the evaluation and become part of the Contract File.
 - h. SMEs to be notified and scheduled in advance of scoring specific sections to provide any information requested prior to scoring a section. The anticipated schedule for Evaluation Areas was provided for planning purposes and notes as subject to change.
 - i. Importance of SMEs reviewing both the RFP as posted/revised and the specific sections of Offeror responses.
 - j. Explained scoring methods. Advised SMEs that they will not be scoring but presenting information on particular areas/sections of the RFP and answering specific questions for the Evaluation Committee to use in scoring.
3. Since some SMEs were unable to attend the sessions on October 23 and October 24, 2018, the Contract Leads worked with SMEs as needed for individual SME Kick-Off Meetings which were scheduled on-demand.

4. Upon completion of the Confidentiality and Conflict of Interest Statements, SMEs were provided access to the *RFP 30-190029-DHB PHP Eval* folder on SharePoint.
5. For a list of all SMEs that participated in the evaluation process, see *Attachment #6 PHP Evaluation SME List*.

October 24, 2018

Evaluation Committee Meeting

Attendees: Melanie Bush, Catherine Pace, Tabitha Bryant, Sabrena Lea, Patrick Doyle, Sheila Platts, Amanda Van Vleet, Kimberley Kilpatrick, Gregory Sligh and SME Sarah Gregosky (attended briefly).

1. Posed the Confidentiality and Conflict of Interest question to the Committee – no conflicts
2. Scored Section VIII., First Restated and Revised Attachment O. Offeror's Proposal and Response, 1. Minimum Qualifications for Aetna Better Health of North Carolina, Inc (Aetna), AmeriHealth Caritas of North Carolina, Inc (AmeriHealth), Blue Cross and Blue Shield of North Carolina Healthy Blue (BCBS), Carolina Complete Health, Inc (CCH), North Carolina Provider Owned Plans, Inc dba My Health by Health Providers (My Health), Optima Family Care of North Carolina (Optima), United HealthCare of North Carolina, Inc (United) and WellCare of North Carolina, Inc (WellCare).
3. The Committee determined all Offerors met the Minimum Qualifications.

October 25, 2018

Evaluation Committee Meeting

Attendees: Sabrena Lea, Patrick Doyle, Tabitha Bryant, Melanie Bush, Catherine Pace, Sheila Platts, Amanda Van Vleet, Kimberley Kilpatrick, Gregory Sligh, and Legal Counsel Lotta Crabtree (attended briefly).

1. Posed the Confidentiality and Conflict of Interest question to the Committee – no conflicts
2. Sarah Gregosky presented information to frame and provide context of the RFP and answer any questions of the Evaluation Committee prior to scoring.
3. Began scoring Offeror Qualifications/Experience for Aetna, AmeriHealth, BCBS, CCH and My Health.
4. The Committee decided to put questions 3, 5, 7, 8, 9 and 10 on hold pending consultation with Lotta Crabtree on scoring criteria. The Committee did not think the scoring criteria/rating definitions fit the questions making it difficult to evaluate.

October 26, 2018

Evaluation Committee Meeting

Attendees: Amanda Van Vleet, Sabrena Lea, Sheila Platts, Patrick Doyle, Tabitha Bryant, Melanie Bush, Catherine Pace, Kimberley Kilpatrick, Gregory Sligh, and Legal Counsel Lotta Crabtree (attended briefly).

1. Posed the Confidentiality and Conflict of Interest question to the Committee – no conflicts
2. Completed scoring Section VIII., First Restated and Revised Attachment O. Offeror's Proposal and Response. 3. Offeror Qualifications/Experience for Optima, United and WellCare but for questions previously tabled.
3. The Committee voiced its concerns to Legal Counsel that the scoring criteria/rating definitions for questions 3, 7, 8, 9, and 10 did not fit the questions making it difficult to evaluate. Lotta Crabtree will review all scoring criteria/rating definitions for the remaining questions and make recommendations regarding criteria/rating definitions based on that review.
4. The Committee proceeded with scoring question 5 for Aetna, AmeriHealth, BCBS, CCH, My Health, Optima and WellCare.

October 30, 2018

Evaluation Committee Meeting

Attendees: Catherine Pace, Melanie Bush, Sheila Platts, Amanda Van Vleet, Tabitha Bryant, Patrick Doyle, Sabrena Lea, Kimberley Kilpatrick and Gregory Sligh.

1. Posed the Confidentiality and Conflict of Interest question to the Committee – no conflicts.
2. Based on consultation with Lotta Crabtree and SMEs modifications to scoring criteria for questions 7, 8, 9, 10 and 15 were made because the Evaluation 5 Level Rating Scale was not appropriate for the questions. The modifications did not change the weight or value of the possible points available, only the criteria/rating definitions.
3. In addition, Lotta Crabtree requested the scoring criteria for questions 56, 57 and 59 be reviewed by the SMEs for this area. Based on SME feedback, modifications were made to the criteria/rating definitions but the weight or value of possible points available did not change.
4. Scoring was completed for questions 3, 7, 8, 9 and 10 for Offerors.
5. Began scoring Section VIII., Scope of Services, Administration and Management, questions 12-19 for Aetna, AmeriHealth and BCBS.

October 31, 2018

Evaluation Committee Meeting

Attendees: Sabrena Lea, Patrick Doyle, Tabitha Bryant, Melanie Bush, Catherine Pace, Sheila Platts, Amanda Van Vleet, Kimberley Kilpatrick and Gregory Sligh.

1. Posed the Confidentiality and Conflict of Interest question to the Committee – no conflicts
2. Completed scoring Section VIII., Scope of Services, Administration and Management, questions 12-19 for CCH, My Health, Optima, United and WellCare.

November 1, 2018

Evaluation Committee Meeting

Attendees: Catherine Pace, Melanie Bush, Sheila Platts, Amanda Van Vleet, Tabitha Bryant, Patrick Doyle, Sabrena Lea, Kimberley Kilpatrick, Gregory Sligh and SME Sarah Gregosky (attended briefly).

1. Posed the Confidentiality and Conflict of Interest question to the Committee – no conflicts
2. Committee continued their discussion on question 19.
3. Sarah Gregosky provided details about question 20 which covered Section V.B. 1. Eligibility for Medicaid Managed Care and Section V.B.2. Medicaid Managed Care Enrollment and Disenrollment.
4. Continued scoring Section VIII., Scope of Services, Administration and Management, questions 12-19 for AmeriHealth and Aetna.

November 6, 2018

Evaluation Committee Meeting

Attendees: Catherine Pace, Melanie Bush, Amanda Van Vleet, Tabitha Bryant, Patrick Doyle, Sabrena Lea, SME Sharon McDougal, SME Lavette Brown, SME Debra Farrington, SME Sonja McLeod, Kimberley Kilpatrick, Gregory Sligh and Sheila Platts (joined later).

1. Posed the Confidentiality and Conflict of Interest question to the Committee – no conflicts
2. Sharon McDougal, Lavette Young, Debra Farrington and Sonya McLeod gave an overview of their review of each response and answered Committee questions for question 20 from Section V.B.1. Eligibility for Medicaid managed Care and Section V.B.2. Medicaid Managed Care Enrollment and Disenrollment.
3. Began scoring questions 20-24 from Section V.B.1. Eligibility for Medicaid Managed Care and Section V.B.1. Medicaid Managed Care Enrollment and Disenrollment for WellCare, United, Optima and My Health.

November 7, 2018

Evaluation Committee Meeting

Attendees: Catherine Pace, Melanie Bush, Amanda Van Vleet, Tabitha Bryant, Patrick Doyle, Sabrena Lea, Kimberley Kilpatrick and Gregory Sligh.

1. Posed the Confidentiality and Conflict of Interest question to the Committee – no conflicts
2. Continued scoring questions 20-24, Section V.B.1. Eligibility for Medicaid managed Care and Section V.B.2. Medicaid Managed Care Enrollment and Disenrollment for CCH, BCBS, AmeriHealth and Aetna.

Note: Secretary Cohen and Amanda Parks made a brief visit to thank the Committee for their work and for being a part of the process. Secretary Cohen was not involved in any discussions of the responses or scoring process, nor were any Offeror responses shared.

November 13, 2018

Evaluation Committee Meeting

Attendees: Catherine Pace, Melanie Bush, Tabitha Bryant, Patrick Doyle, Kimberley Kilpatrick, Gregory Sligh, Amanda Van Vleet and SME Dr. Nancy Henley (attended briefly via call in until she arrived).

1. Posed the Confidentiality and Conflict of Interest question to the Committee – no conflicts.
2. Began scoring questions 25-31 from the Benefits and Care Management section for Aetna and AmeriHealth.
3. Committee decided to delay scoring question 29 until SME John Stancil could attend.
4. Dr. Nancy Henley reviewed each response and answered Committee questions for this section.

November 14, 2018

Evaluation Committee Meeting

Attendees: Catherine Pace, Melanie Bush, Tabitha Bryant, Patrick Doyle, Sheila Platts, Sabrena Lea, Kimberley Kilpatrick, Gregory Sligh, Amanda Van Vleet, SME Kelsi Knick (attended briefly) and Leadership Mona Moon (attended briefly).

1. Posed the Confidentiality and Conflict of Interest question to the Committee – no conflicts.
2. Continued scoring questions 25-31 minus question 29 from the Benefits and Care Management section for BCBS.
3. Kelsi Knick joined to provide comments and answer Committee questions for Benefits and Care Management.

4. Question 25 for BCBS was not scored after discussion with Kelsi Knick as to whether the LME/MCOs will be providing care coordination for Behavioral Health services for BCBS's PHP. The Committee discussed requesting a clarification pending a consultation with Sarah Gregosky, Kelsi Knick and Lotta Crabtree.

November 15, 2018

Evaluation Committee Meeting

Attendees: Catherine Pace, Melanie Bush, Sheila Platts, Amanda Van Vleet, Tabitha Bryant, Patrick Doyle, Sabrena Lea, SME Dr. Nancy Henley (attended briefly), SME John Stancil (attended briefly), Kimberley Kilpatrick and Gregory Sligh.

1. Posed the Confidentiality and Conflict of Interest question to the Committee – no conflicts.
2. John Stancil provided assessment of question 29 in the Benefits and Care Management section.
3. Dr. Nancy Henley provided overall assessment, general comments and answered any Committee questions for Care Management.
4. Committee resumed scoring questions 25-31 minus question 29 from the Benefits and Care Management section for CCH, My Health, Optima and United.

November 16, 2018

Evaluation Committee Meeting

Attendees: Catherine Pace, Melanie Bush, Amanda Van Vleet, Tabitha Bryant, Patrick Doyle, Sabrena Lea, Kimberley Kilpatrick, Gregory Sligh and SME Sarah Gregosky (attended briefly).

1. Posed the Confidentiality and Conflict of Interest question to the Committee – no conflicts.
2. Committee resumed scoring for question 29 from the Benefits and Care Management section for WellCare, United and Optima.
3. Sarah Gregosky provided details concerning questions 55 and 56 for the Claims and Encounter Management section.

November 19, 2018

Attendees: Catherine Pace, Melanie Bush, Sheila Platts, Amanda Van Vleet, Tabitha Bryant, Patrick Doyle, Sabrena Lea, Kimberley Kilpatrick, Gregory Sligh, SME Cheryl McQueen (attended briefly), SME Adolph Simmons (attended briefly), SME Kelsi Knick (attended briefly), Legal Counsel Lotta Crabtree (attended briefly), SME Sarah Gregosky (attended briefly) and SME Dr. Nancy Henley (attended briefly).

1. Posed the Confidentiality and Conflict of Interest question to the Committee – no conflicts.

2. Cheryl McQueen and Adolph Simmons provided details concerning questions 56 from the Claims and Encounter Management section.
3. Dr. Nancy Henley returned and completed her comments for Care Management.
4. Committee began scoring questions 56 from the Claims and Encounter Management section for My Health, Optima, United, WellCare, Aetna, AmeriHealth and BCBS.
5. Kelsi Knick, Sarah Gregosky and Lotta Crabtree attended to discuss the need for a clarification from BCBS regarding its response to 25. It was determined a clarification was needed.
6. BCBS Clarification #1 issued. See *Table 2 – Offeror Clarifications*.

November 20, 2018

Evaluation Committee Meeting

Attendees: Catherine Pace, Melanie Bush, Sheila Platts, Amanda Van Vleet, Tabitha Bryant, Patrick Doyle, Sabrena Lea, SME Adolph Simmons (attended briefly), Kimberley Kilpatrick and Gregory Sligh.

1. Posed the Confidentiality and Conflict of Interest question to the Committee – no conflicts.
2. Committee continued scoring question 56 from the Claims and Encounter Management section for CCH.
3. Adolph Simmons responded to additional questions from the Committee concerning question 56.

November 26, 2018

Evaluation Committee Meeting

Attendees: Catherine Pace, Sheila Platts, Tabitha Bryant, Melanie Bush, Patrick Doyle, Sabrena Lea, Kimberley Kilpatrick and Gregory Sligh.

1. Posed the Confidentiality and Conflict of Interest question to the Committee – no conflicts.
2. Committee scored question 55 from the Claims and Encounter Management section for My Health, Optima, United, WellCare, Aetna, AmeriHealth, BCBS and CCH.
3. BCBS Clarification #1 reviewed with Committee and determined to have clarified the concern. Completed scoring question 25 for BCBS.

November 27, 2018

Evaluation Committee Meeting

Attendees: Catherine Pace, Sheila Platts, Tabitha Bryant, Melanie Bush, Patrick Doyle, Sabrena Lea, SME Jean Holliday (attended briefly), Kimberley Kilpatrick and Gregory Sligh.

1. Posed the Confidentiality and Conflict of Interest question to the Committee – no conflicts.
2. Committee scored question 55 from the Claims and Encounter Management section for My Health, Optima, United, WellCare, Aetna, AmeriHealth, BCBS and CCH.
3. Jean Holliday gave comments on question 55 from the Claims and Encounter Management section. She also indicated the need to issue Clarifications to CCH and United for review of question 11 regarding commitment to offer Qualified Health Plans (QHPs) in NC. Clarifications to be drafted and issued. See *Table 2 – Offeror Clarifications* for additional information.

Contracting Team Note: Offeror Client References were emailed November 27, 2018. Kimberley Kilpatrick emailed each reference contact and included the Client Reference Survey Template for each request. See *Attachment #8 Offeror Client Reference Questionnaire Template*. Responses for Client References were scored as received by the Committee. *Table 1 – Offeror Client Reference Check Tracking* documents the requests and follow up activities to obtain all Offeror references.

November 28, 2018

Evaluation Committee Meeting

Attendees: Catherine Pace, Melanie Bush, Sheila Platts, Tabitha Bryant, Patrick Doyle, Sabrena Lea (by phone), SME Kelly Crosbie (attended briefly), SME Dr. Nancy Henley (attended briefly), SME Kelsi Knick (attended briefly), SME Erica Ferguson (attended briefly by phone), SME Beth Lovett (attended briefly by phone), Legal Counsel Lotta Crabtree (attend briefly), Kimberley Kilpatrick, Gregory Sligh and Leadership Mona Moon (attended briefly).

1. Posed the Confidentiality and Conflict of Interest question to the Committee – no conflicts.
2. Kelly Crosbie, Dr. Nancy Henley, Kelsi Knick, Erica Ferguson and Beth Lovett by phone, gave their comments and observations concerning questions 32 – 38 for the Benefits and Care Management section.
3. Committee began scoring question 32 – 38 for United.
4. Committee consulted with Lotta Crabtree regarding LME/MCO authority. Crabtree to research issue and follow up with Committee.

Note: Mona Moon attended 8:30 – 9:30 to discuss the evaluation schedule with the Evaluation Committee, including the areas remaining and suggestions for completing the evaluation within the scheduled timeframe.

November 29, 2018

Evaluation Committee Meeting

Attendees: Catherine Pace, Melanie Bush, Sheila Platts, Tabitha Bryant, Patrick Doyle, Sabrena Lea, Kimberley Kilpatrick, Gregory Sligh.

1. Posed the Confidentiality and Conflict of Interest question to the Committee – no conflicts.
2. Committee continued scoring question 32 – 38 for the Benefits and Care Management section for WellCare, Aetna, AmeriHealth and BCBS.

Note: CCH Clarification #1 issued 11/29/2018. The United Clarification #1 issued 11/29/2018. Clarifications would be discussed with question #11. See *Table 2 – Offeror Clarifications* for additional information.

November 30, 2018

Evaluation Committee Meeting

Attendees: Melanie Bush, Sheila Platts, Amanda Van Vleet, Tabitha Bryant, Patrick Doyle, SME Sarah Gregosky (attended briefly), SME Kelsi Knick (by phone), Kimberley Kilpatrick and Gregory Sligh.

1. Posed the Confidentiality and Conflict of Interest question to the Committee – no conflicts.
2. Committee continued scoring question 32 – 38 for the Benefits and Care Management section for CCH, My Health and Optima.
3. Kelsi Knick called in to answer questions concerning Benefits and Care Management.
4. Sarah Gregosky explained the Stakeholders Engagement section, questions 47-49.

Note: CCH Clarification #1 was returned 11/30/2018. United Clarification #1 was returned 11/30/2018. Clarifications would be reviewed when the Committee reconvened to discuss question 11 commitment to offer QHPs. See *Table 2 – Offeror Clarifications* for additional information.

December 3, 2018

Evaluation Committee Meeting

Attendees: Melanie Bush, Sheila Platts, Tabitha Bryant, Patrick Doyle, Amanda Van Vleet (by phone), Sabrena Lea (by phone), Legal Counsel Lotta Crabtree (attended briefly), Kimberley Kilpatrick and Gregory Sligh.

1. Posed the Confidentiality and Conflict of Interest question to the Committee – no conflicts.
2. Lotta Crabtree addressed the Committee's question regarding the LME/MCOs ability to contract with the PHPs. The question was a general question by the Committee and not for clarifying or scoring a particular response.

December 4, 2018

Evaluation Committee Meeting

Attendees: Cathy Pace, Melanie Bush, Amanda Van Vleet, Tabitha Bryant, Patrick Doyle, Sabrena Lee, Sheila Platts, Kimberley Kilpatrick and Gregory Sligh.

1. Posed the Confidentiality and Conflict of Interest question to the Committee – no conflicts.
2. Committee began scoring questions 47-49 for the Stakeholder Engagement section.

December 5, 2018

Evaluation Committee Meeting

Attendees: Cathy Pace, Melanie Bush, Sheila Platts, Tabitha Bryant, Patrick Doyle, Sabrena Lee, Amanda Van Vleet, SME Debra Farrington (attended briefly), SME Lynne Teste (attended briefly), SME Sharon McDougal (attended briefly), Kimberley Kilpatrick and Gregory Sligh.

1. Posed the Confidentiality and Conflict of Interest question to the Committee – no conflicts.
2. Debra Farrington Lynn Testa and Sharon McDougal talked to the Committee about Stakeholder Engagement questions 47-49.
3. Committee completed scoring for question 47-49.

December 6, 2018

Evaluation Committee Meeting

Attendees: Cathy Pace, Sheila Platts, Amanda Van Vleet, Tabitha Bryant, Patrick Doyle, Sabrena Lee, Kimberley Kilpatrick and Gregory Sligh.

1. Posed the Confidentiality and Conflict of Interest question to the Committee – no conflicts.
2. Committee began scoring the Compliance section, questions 60-63 for Optima, CCH, My Health, United, WellCare and BCBS.

December 7, 2018

Evaluation Committee Meeting

Attendees: Cathy Pace, Sheila Platts, Amanda Van Vleet, Tabitha Bryant, Patrick Doyle, Sabrena Lee (by phone), SME Sarah Gregosky (attended briefly), Kimberley Kilpatrick and Gregory Sligh.

1. Posed the Confidentiality and Conflict of Interest question to the Committee – no conflicts.
2. Committee completed scoring questions 60-63 for Aetna and AmeriHealth.

3. Sarah Gregosky explained the various parts of the Program Operations questions.

December 12, 2018

Evaluation Committee Meeting

Attendees: Cathy Pace, Melanie Bush, Amanda Van Vleet, Tabitha Bryant, Patrick Doyle, SME Janice Norris (attended briefly), SME Sarah Gregosky (attended briefly), Kimberley Kilpatrick and Gregory Sligh.

1. Posed the Confidentiality and Conflict of Interest question to the Committee – no conflicts
2. Janice Norris and Sarah Gregosky provided an overview of the responses and answered the Committee's questions on the Programs Operations section.
3. The Committee began scoring questions 50-54 of the Program Operations section for Aetna, AmeriHealth, BCBS, CCH, My Health and Optima.

December 13, 2018

Evaluation Committee Meeting

Attendees: Cathy Pace, Melanie Bush, Sheila Platts, Tabitha Bryant, Patrick Doyle, Amanda Van Vleet, Sabrena Lea, SME Cheryl McQueen (attended briefly), SME Jase Slaughter (attended briefly), SME Pyreddy Reddy (attended briefly), SME Steve Tedder (attended briefly), SME Angela Taylor (attended briefly), SME Rajeev Kotrannavar (initially by phone, attended briefly), Gregory Sligh and Kimberley Kilpatrick (called in briefly).

1. Posed the Confidentiality and Conflict of Interest question to the Committee – no conflicts.
2. Cheryl McQueen, Jase Slaughter, Pyreddy Reddy, Steve Tedder, Angela Taylor provided an overview of the responses and answered the Committee's question for questions 64 and 65.
3. The Committee completed scoring questions 50-54 of the Program Operations section for United and WellCare.
4. The Committee began and completed scoring questions 64 and 65 for Aetna, AmeriHealth, BCBS, CCH, My Health Care, Optima, United and WellCare.

December 15, 2018

Contracting Team Activities: Follow up emails were sent to Offeror references regarding outstanding questionnaires. See *Table 1 – Offeror Client Reference Check Tracking*.

December 17, 2018

Evaluation Committee Meeting

Attendees: Cathy Pace, Patrick Doyle, Sheila Platts, Sabrena Lea, Amanda Van Vleet, Melanie Bush, Tabitha Bryant, SME Deirdre Brown (attended briefly), SME Alfred Greco (attended briefly), SME Jean Holliday (attended briefly), SME Julia Lerche (attended briefly), Kimberley Kilpatrick and Gregory Sligh.

1. Posed the Confidentiality and Conflict of Interest question to the Committee – no conflicts.
2. Deirdre Brown, Alfred Greco, Jean Holliday and Julia Lerche provided an overview of the responses and answered the Committee's questions on the Financial Requirements section for questions 57 – 59.
3. The Committee began and completed scoring questions 57-59 of the Financial Requirements section for Aetna, AmeriHealth, BCBS, CCH, My Health, Optima, United and WellCare.
4. The Committee decided to not score question 59.a. for BCBS until a clarification was obtained and Committee could consult with SME Jean Holliday.

December 18, 2018

Evaluation Committee Meeting

Attendees: Cathy Pace, Patrick Doyle, Sheila Platts, Melanie Bush, Sabrena Lea, Tabitha Bryant, Amanda Van Vleet, SME John Thompson (attended briefly), SME Sarah Gregosky (attended briefly), Kimberley Kilpatrick and Gregory Sligh.

1. Posed the Confidentiality and Conflict of Interest question to the Committee – no conflicts.
2. John Thompson provided an overview of the responses and answered the Committee's questions on the Compliance section for questions 60 – 63.
3. The Committee began scoring Offeror's Client References for Aetna ([REDACTED]), AmeriHealth (Delaware, Michigan), BCBS (Maryland, South Carolina), CCH (New Hampshire, Kansas, Superior HealthPlan, Inc. of Texas), My Health ([REDACTED]), Optima (Huntsville Hospital Health System, Virginia Division of Medical Services – Operations, Virginia Division of Medical Services – Integrated Care), United (Michigan Department of Health and Human Services, Rhode Island Department of Health and Human Services, Kansas KDHE) and WellCare (Staywell Health Plan of Florida).
4. The Committee asked to consult with Lotta Crabtree concerning BCBS's use of BlueChoice Health Plan of South Carolina as a reference and Optima's use of Huntsville Hospital Health System. Pending on the consultation the references were not scored.
5. Sarah Gregosky gave an overview of Use Case Scenarios.

Contracting Team Note: Kimberley Kilpatrick called Lotta Crabtree and posed the questions from the Committee on the two references in Item #4 above. Advised the Committee to be consistent in determining if the reference was a client reference and relevant to the scope of services.

December 19, 2018

Evaluation Committee Meeting

Attendees: Cathy Pace, Melanie Bush, Sheila Platts, Tabitha Bryant Patrick Doyle, Sabrena Lea, SME Jean Holliday (attended briefly), Amanda Van Vleet, Kimberley Kilpatrick and Gregory Sligh.

1. Posed the Confidentiality and Conflict of Interest question to the Committee – no conflicts.
2. Jean Holliday explained question 11, commitment to offer QHPs, scoring. Reviewed the information obtained as part of CCH Clarification #1 and United Clarification #1. Committee scored question 11 based on the information provided by Jean Holliday. See *Attachment #9 Question 11 Data* and *Attachment #10 Question 11 NC County Exchange Enrollment* for information on how the points were calculated and responses scored
3. The Committee scored a reference for Aetna ([REDACTED]).
4. Legal Counsel Lotta Crabtree advised the Committee to be consistent in their consideration, treatment and scoring of references. Based on the consultation for the BCBS and Optima references on December 18 for Item #4, the consensus was to not score the references as the BCBS reference was deemed not a “client reference” and services were never implemented for the Optima reference.

SME Activity Note: Prior to meeting with the Committee to review question 11, quality assurance and verification of the data and formulas were conducted by SMEs Jean Holliday and Sarah Gregosky.

December 20, 2018

Contract Team Note: BCBS Clarification #2 to confirm Financial Management question 56 issued 12/20/2018 and returned 12/20/2018. SME Jean Holliday reviewed and confirmed it provided the necessary information. Jean will share with Committee upon return in January 2019. See *Table 2 – Offeror Clarifications* for additional information.

January 2, 2019

Evaluation Committee Meeting

Attendees: Sheila Platts, Cathy Pace, Patrick Doyle, Amanda Van Vleet, Melanie Bush, Sabrena Lea, SME Reginald Little (attended briefly), SME Lynne Testa (attended briefly), SME Julia Lerche (attended briefly), SME Jean Holliday (attended briefly), Kimberley Kilpatrick and Gregory Sligh.

1. Posed the Confidentiality and Conflict of Interest question to the Committee – no conflicts.

2. Reginald Little, Lynne Testa, Julia Lerche and Jean Holliday provided an overview of the responses and answered the Committee's questions on the Providers section, questions 40-44.
3. Information on BCBS Clarification #2 shared and the Committee determined that it did not impact scoring for BCBS question 56.
4. The Committee began and completed scoring question 43 of the Providers section for Aetna, AmeriHealth, BCBS, CCH, My Health, Optima, United and WellCare.
5. The Committee started scoring the remaining questions, 40, 41, 42 and 44 of the Providers section for Aetna, AmeriHealth BCBS and CCH.

January 3, 2019

Evaluation Committee Meeting

Attendees: Sheila Platts, Cathy Pace, Melanie Bush, Patrick Doyle, Amanda Van Vleet, SME Jean Holliday (by phone), Kimberley Kilpatrick and Gregory Sligh.

1. Posed the Confidentiality and Conflict of Interest question to the Committee – no conflicts.
2. Jean Holliday called in to clarify the Committee's question on Evergreen contracts.
3. The Committee resumed scoring the Providers section, questions 40, 41, 42, and 44 for My Health, Optima, United and WellCare.
4. Client References were scored for AmeriHealth Caritas (Louisiana department of Health) and Carolina Complete Health (Managed Health Services, Inc. "MHS").

January 7, 2019

Evaluation Committee Meeting

Attendees: Sheila Platts, Cathy Pace, Amanda Van Vleet, Tabitha Bryant, Melanie Bush, SME Terri Pennington (attended briefly), SME Jaimica Wilkins (attended briefly), SME Kelly Crosbie (attended briefly), Kimberley Kilpatrick and Gregory Sligh.

1. Posed the Confidentiality and Conflict of Interest question to the Committee – no conflicts.
2. Terri Pennington, Jaimica Wilkins and Kelly Crosbie presented their findings on question 45 and 46 for Quality and Value in Section V.E.1. Quality Management and Quality Improvement.
3. The Committee began and completed Quality and Value, questions 45 and 46 for Aetna, AmeriHealth, BCBS, CCH, My Health, Optima, United and WellCare.
4. Shared that Negotiation Document #1 would be sent to all Offerors to incorporate revisions necessary to the RFP based on factors such as CMS waiver approval. The Offerors were to accept the revisions and return. A copy of the Negotiation Document was placed on SharePoint for the Committee to review.

Contracting Process Note: The Contracting Leads reviewed a list of items in the Offerors' responses that were noted by the Committee as potential conflicts or technical issues with regards to RFP requirements to determine if clarifications were necessary. The Contracting Leads would discuss the list with Legal Counsel and appropriate SMEs and issue clarifications as needed.

January 8, 2019

Evaluation Committee Meeting

Attendees: Sheila Platts, Cathy Pace, Amanda Van Vleet, Melanie Bush, Sabrena Lea, Tabitha Bryant, SME Jean Holliday (attended briefly), SME Dr. Nancy Henley (attended briefly), Lotta Crabtree (by phone), Kimberley Kilpatrick and Gregory Sligh.

1. Posed the Confidentiality and Conflict of Interest question to the Committee – no conflicts.
2. Jean Holliday presented BCBS Clarification #2 for quota share agreement as a part of BCBS's response for question 59 of the Financial Requirements section.
3. The Committee scored question 59.a. for BCBS after receiving the clarification.
4. The Committee scored the Offeror's Client References section for Aetna ([REDACTED]), AmeriHealth Caritas (South Carolina Department of Health and human services) and WellCare (WellCare of New Jersey, Inc.).
5. Dr. Nancy Henley provided an overview of the responses and answered the Committee's questions on Use Case Scenarios 1-5 for Aetna, AmeriHealth, BCBS, CCH, My Health, Optima, United and WellCare.
6. Consulted Lotta Crabtree by phone regarding scoring criteria for Use Case Scenarios.
7. Scoring completed for Use Case Scenario 1 for Aetna, AmeriHealth, BCBS, CCH, My Health, Optima and United.
8. Negotiation Document #1 issued to all Offerors. See *Table 3 – Offeror Negotiation Documents*.

January 9, 2019

Evaluation Committee Meeting

Attendees: Tabitha Bryant, Sheila Platts, Cathy Pace, Patrick Doyle, Melanie Bush, Amanda Van Vleet, SME Dr. Dr. Nancy Henley (attended briefly), Sabrena Lea (by phone), Kimberley Kilpatrick and Gregory Sligh.

1. Posed the Confidentiality and Conflict of Interest question to the Committee – no conflicts.
2. The Committee continued scoring Use Case Scenarios 1 for WellCare and Use Case Scenarios 2, 3, 4, 5 and 7 for Aetna, AmeriHealth, BCBS, CCH, My Health, Optima, United and WellCare.

3. Dr. Nancy Henley was consulted regarding CCH/Centene's plan with Community Care Networks and My Health's with Presbyterian Hospital in responses to the Use Case scenarios.

January 10, 2019

Evaluation Committee Meeting

Attendees: Sabrena Lea, Melanie Bush, Tabitha Bryant, Cathy Pace, Amanda Van Vleet, Patrick Doyle, Kimberley Kilpatrick and Gregory Sligh.

1. Posed the Confidentiality and Conflict of Interest question to the Committee – no conflicts.
2. The Committee scored Use Case Scenario 6 for Aetna, AmeriHealth, BCBS, CCH, My Health, United and WellCare.

January 11, 2019

Attendees: Sheila Platts, Melanie Bush, Tabitha Bryant, Cathy Pace, Amanda Van Vleet, Patrick Doyle, Sabrena Lea, SME Kelly Crosbie (attended briefly), SME Kelsi Knick (attended briefly), Kimberley Kilpatrick and Gregory Sligh.

1. Posed the Confidentiality and Conflict of Interest question to the Committee – no conflicts.
2. Kelly Crosbie and Kelsi Knick answered questions concerning what role LME/MCOs may assume with Care Management.
3. Based on a review by the Contracting Team (see January 7, Contracting Process Note), clarifications would be issued to the following Offeror's for confirmation of adherence to RFP requirements:
 - a. Aetna Clarification #1
 - b. AmeriHealth Clarification #1
 - c. CCH Clarification #2
 - d. Optima Clarification #1.

These Clarifications were issued January 13, 2019. See *Table 2 – Offeror Clarifications* for additional information.

January 14, 2019

Evaluation Committee Meeting

Attendees: Sheila Platts, Melanie Bush, Tabitha Bryant, Cathy Pace, Amanda Van Vleet, Sabrena Lea, Kimberley Kilpatrick, Patrick Doyle (by phone) and Gregory Sligh (by phone).

1. Posed the Confidentiality and Conflict of Interest question to the Committee – no conflicts.

2. The Committee agreed to meet the following day to review the scores to confirm the documentation for scores of Partially Meets/Does Not Meet was clear, consistent across all Offerors and sufficiently detailed. See *Table 4 – Scoring Validation Partially Meets/Does Not Meet*. This exercise would be one of several quality assurance reviews to ensure consistency and accuracy of the score.
3. Confirmed all Negotiation Documents #1 had been properly executed and returned by each Offeror.

January 15, 2019

Evaluation Committee Meeting

Attendees: Sheila Platts, Melanie Bush, Tabitha Bryant, Cathy Pace, Amanda Van Vleet, Sabrena Lea, Patrick Doyle, Gregory Sligh and Kimberley Kilpatrick.

1. Posed the Confidentiality and Conflict of Interest question to the Committee – no conflicts.
2. The Committee completed review of scores for Partially Meets/Does Not Meet to ensure the scores were clear, consistent across all Offerors and sufficiently detailed.

Contracting Team Note: As part of the quality assurance process, Mona Moon inquired about the status of outstanding references. Kimberley Kilpatrick noted the dates of requests and follow ups for references that were still outstanding. After discussing with Lotta Crabtree, the decision was made to send a final request for all outstanding Offeror Client References with a due date/time of January 17, 9:00 AM EST. Kimberley Kilpatrick issued the follow up requests January 16 by 9:30 AM for all outstanding references. Information for the dates of all reference requests and follow ups are documented in *Table 1 – Offeror Client Reference Check Tracking*.

January 16, 2019

9:00 AM Evaluation Committee Meeting

Attendees: Sheila Platts, Melanie Bush, Tabitha Bryant, Cathy Pace, Amanda Van Vleet, Sabrena Lea, Patrick Doyle, Leadership Mona Moon, SME Sarah Gregosky, Legal Counsel Lotta Crabtree, Kimberley Kilpatrick and Gregory Sligh.

1. Posed the Confidentiality and Conflict of Interest question to the Committee – no conflicts.
2. Mona Moon reviewed the remaining steps of the process leading up to the announcement of awards, including continued quality review activities of the scores to ensure consistency and accuracy.
3. Mona explained the process for the last request made for Offeror's outstanding client references which were due no later than January 17 by 9:00 AM EST.

4. Aetna Clarification #1, AmeriHealth Clarification #1, CCH Clarification #2 and Optima Clarification #1 were reviewed and discussed with Mona Moon, Lotta Crabtree, Sarah Gregosky and the Committee. No scores were changed based on these Clarifications.
5. Discussion of the Clarifications in Item #4 above generated a discussion on the United response and role of the LME/MCOs.
6. Based on the discussion Lotta Crabtree will draft Clarification #2 for United concerning care management and LME/MCOs and bring back to the Committee for review at 3:30 PM.

3:00 PM Contract Team and SME Meeting

Attendees: Jim Bard, Brandon Brown, Mona Moon, Kimberley Kilpatrick and Gregory Sligh.

Excel SMEs James Bard and Brandon Brown checked the scoring spreadsheet to make sure formulas and links between worksheets were correct. All formatting errors were corrected. A few technical errors (i.e., incorrect cell reference in a formula) were discovered and corrected. These technical errors did not change or affect any scores. Brandon Brown confirmed the totals on each of the individual sheets matched the summary totals.

3:30 PM Evaluation Committee Meeting

Attendees: Sheila Platts, Melanie Bush, Tabitha Bryant, Cathy Pace, Amanda Van Vleet, Sabrena Lea, Patrick Doyle, Leadership Mona Moon, SME Sarah Gregosky, Legal Counsel Lotta Crabtree, SME Kelsi Knick, Kimberley Kilpatrick and Gregory Sligh.

Draft United Clarification #2 reviewed with the Committee. Clarification to be revised based on Committee feedback and will be presented to the Committee for review on January 17.

January 17, 2019

Evaluation Committee Meeting

Attendees: Sheila Platts, Melanie Bush, Tabitha Bryant, Cathy Pace, Amanda Van Vleet, Sabrena Lea, Patrick Doyle, Leadership Mona Moon, SME Sarah Gregosky (attended briefly), Legal Counsel Lotta Crabtree (attended briefly), SME Kelsi Knick (attended Briefly), Kimberley Kilpatrick and Gregory Sligh.

1. Posed the Confidentiality and Conflict of Interest question to the Committee – no conflicts.
2. Lotta Crabtree reviewed the draft United Clarification #2 with the Committee and Kelsi Knick who provided input and the draft was finalized.
3. The Clarification will be sent January 17 requesting the response returned no later than January 18 by 9:00 AM.
4. Client Reference scored for WellCare (WellCare of Kentucky, Inc. "WCKY").

5. The Committee agreed to reconvene January 18 at 10:30 AM to review the United Clarification #2.
6. The Committee reviewed the scores to confirm the documentation for scores of Exceeds/Substantially Exceeds were clear and detailed where possible. See *Table 5 – Scoring Validation Exceeds/Substantially Exceeds*.

January 18, 2019

Three separate Meetings were held.

Evaluation Committee Meeting #1 at 10:30 AM

Attendees: Sheila Platts, Melanie Bush, Tabitha Bryant (by phone), Cathy Pace, Amanda Van Vleet, Sabrena Lea, Patrick Doyle, Leadership Mona Moon, Legal Counsel Lotta Crabtree (part phone and in-person), SME Kelsi Knick, Kimberley Kilpatrick and Gregory Sligh.

1. Posed the Confidentiality and Conflict of Interest question to the Committee – no conflicts.
2. United submitted their response to the Clarification #2 request before the 9:00 a.m. deadline. See *Table 2 – Offeror Clarifications* for additional information.
3. The Committee reviewed United's Clarification #2 response. No scores were changed based on the Clarification.
4. The Committee having completed a review and scoring of all questions agreed to meet at 12:00 PM to review the scores for the first time with the understanding that quality assurance activities were on-going and scores would not be final until that process is complete.

Evaluation Committee Meeting #2, 12:00 PM

Attendees: Sheila Platts, Melanie Bush, Tabitha Bryant (by phone), Cathy Pace, Amanda Van Vleet, Sabrena Lea, Patrick Doyle, Leadership Mona Moon, Legal Counsel Lotta Crabtree, Kimberley Kilpatrick and Gregory Sligh.

1. Posed the Confidentiality and Conflict of Interest question to the Committee – no conflicts.
2. A summary of the scores was reviewed and discussed.

Evaluation Committee Meeting #3 at 2:30 PM

Attendees: Sheila Platts, Melanie Bush, Tabitha Bryant (by phone), Cathy Pace, Amanda Van Vleet, Sabrena Lea, Patrick Doyle, Leadership Mona Moon, Legal Counsel Lotta Crabtree (by phone), Leadership Jay Ludlam (briefly by phone), SME Sarah Gregosky, Kimberley Kilpatrick and Gregory Sligh.

1. Posed the Confidentiality and Conflict of Interest question to the Committee – no conflicts.

2. A summary of the scores was reviewed and discussed.
3. The Committee completed a quality assurance review to ensure the scores of Exceeds/Substantially Exceeds were clear, consistent across all Offerors and sufficiently detailed.
4. The next step of the quality assurance process is for Lotta Crabtree to review the scoring of Offeror Client References.

January 22, 2019

Evaluation Committee Meeting

Attendees: Sheila Platts, Amanda Van Vleet, Melanie Bush (by phone), Tabitha Bryant, Cathy Pace, Sabrena Lea, Patrick Doyle, Leadership Mona Moon, Leadership Jay Ludlum, Legal Counsel Lotta Crabtree, SME Sarah Gregosky, Kimberley Kilpatrick and Gregory Sligh.

1. Posed the Confidentiality and Conflict of Interest question to the Committee – no conflicts.
2. As part of the quality assurance process, Kimberley Kilpatrick presented to the Committee her findings when performing a validation in the scoring tools on January 19.
 - a. **AmeriHealth:** Question #47 was scored as “exceeds” in the PHP Consensus Scoring Excel file incorrectly, as the score by the Committee was “meets.” Correction adjusted AmeriHealth from 711.25571 to 706.66204.
 - b. **CCH:** Use Case Scenario #6 in the PHP Consensus Scoring Excel file drop-down box was blank and did not calculate the points for “meets.” Updated box to reflect “meets” and calculate the points. Client Reference #1 had the information correct in the notes, but the drop-down boxes were blank and did not calculate the points for “relevant” and “satisfied.” Correction adjusted CCH from 612.64969 to 628.39969.
 - c. **WellCare:** Use Case Scenario #4 in the PHP Consensus Scoring Excel file drop-down box was blank and did not calculate the points for “meets.” Updated the box to reflect “meets” and calculate the points. This correction adjusted WellCare from 731.99304 to 736.19304.
 - d. Committee confirmed scores and supporting reasons for corrections in the PHP Consensus Scoring Excel file. Corrections made.
3. The Committee also discussed the findings of the overall review of Offeror Client References conducted by Lotta Crabtree.
 - a. The Committee did not initially score BCBS’s reference from BlueChoice Health Plan of South Carolina because they determined it was not a “client” reference (See December 19, #4). However, a reference for Aetna from [REDACTED] was scored. Legal Counsel presented to the Committee that the relationship between BlueChoice Health Plan and Amerigroup and that of Aetna and [REDACTED] appeared similar.
 - b. Following discussion by the Committee it was determined that the reference for Amerigroup Partnership Plan, LLC from BlueChoice Health Plan of South Carolina should be scored for BCBS and the scoring was updated accordingly.

3. A summary of the scores was reviewed and discussed, and the Committee determined its award recommendation to be as follows, based on the scores:
 - a. AmeriHealth Caritas North Carolina, Inc.
 - b. Blue Cross and Blue Shield of North Carolina
 - c. UnitedHealthcare of North Carolina, Inc.
 - d. WellCare of North Carolina
6. The Committee discussed whether to recommend award of a regional contract. Only two Offerors are eligible for regional contracts, CCH and Optima. CCH and Optima are the lowest scoring Offerors by a margin of more than 75 points relative to the fourth highest scoring Offeror. Optima's total score indicates the Offeror, on average, failed to achieve the threshold to "meet expectations," i.e. 60% of the total possible points or 615. Awarding a contract to CCH would result in making an award over higher scoring and more technically capable Offerors. While those higher scoring Offerors are not eligible for regional contracts, the Committee did not recommend an award to CCH given their significantly lower technical score.
7. While the Committee reached consensus on the award recommendation based on the scores, the recommendation was subject to change pending completion of all QA activities and resulting final scores. A final comparison of the handwritten scores and related notes (Scoring Notebook) in the form of *Attachment # 7 PHP Scoring Guide* with the Excel Scoring Spreadsheet, *Attachment #11 PHP Consensus Scoring Excel File*, was still required.

January 24, 2019

Evaluation Committee Meeting

Attendees: Tabitha Bryant, Cathy Pace, Amanda Van Vleet, Sheila Platts (by phone), Melanie Bush (by phone), Sabrena Lea (by phone), Patrick Doyle (by phone), Leadership Mona Moon, Legal Counsel Lotta Crabtree, SME Sarah Gregosky, Kimberley Kilpatrick and Gregory Sligh.

1. Posed the Confidentiality and Conflict of Interest question to the Committee – no conflicts.
2. Meeting called to discuss the final quality review activity of the scores conducted to ensure consistency and accuracy.
3. Sarah Gregosky and Greg Sligh compared the Scoring Notebook with the Excel Scoring Spreadsheet. Three (3) inconsistencies were discovered for question 5., Attachment O. Offeror's Proposal and Response Table 3: Entities performing core functions or with proposed experience as follows:
 - a. BCBS had entity EyeMed Vision Care, LLC listed twice.
 - b. My Health was scored Experience: "Meets" for its entity Community Care Partners of Greater Mecklenburg. All other CCNC Networks were scored Experience: "Exceeds" for the same question.

- c. United had its entity eviCore scored “Substantially Exceeds” in the Scoring Notebook and “Exceeds” in the sExcel Scoring Spreadsheet.

Following discussion by the Committee it was determined that the duplication for BCBS should be deleted, Community Care Partners of Greater Mecklenburg for My Health should be scored “Exceeds” and United’s score for eviCore should be “Substantially Exceeds”.

4. The scoring was updated accordingly but did not change significantly and did not alter the recommendation of the Committee.
5. The Committee confirmed its January 22, 2019 award recommendation based on the final scoring and associated ranking of the offerors as follows:

RFP #30-190029-DHB - Prepaid Health Plans				
Highest Scoring Offer, Ranked 1st			736.19304	71.824%
Type of Contract	Rank	Offeror Name	Weighted Total Score	Percentage of Total Possible Points
Statewide	1	WellCare Health Plans	736.19304	71.824%
Statewide	2	United Health Care	727.76474	71.001%
Statewide	3	BCBSNC – Healthy Blue	712.22431	69.485%
Statewide	4	AmeriHealth Caritas North Carolina	706.66204	68.943%
Statewide	5	Aetna	704.60144	68.742%
Statewide	6	My Health by Health Providers	629.71280	61.435%
Either	7	Carolina Complete Health	628.39969	61.307%
Regional	8	Optima Health	573.48539	55.950%
Total Possible Score			1025.00000	
Total Possible If All Scores Meet Expectations (80%)			815.00000	
Offeror is a PLE				
Offeror did not achieve average score of Meets				

Table 1 - Offeror Client Reference Check Tracking

	Initial Email Request	Follow Up Email	Follow Up Call with Email	Final Interview Date
Aetna				
[REDACTED]	11/27/2018	12/15/2018	N/A – Returned 12/18/2018	N/A
[REDACTED]	11/27/2018	12/15/2018	01/03/2019 Left message with [REDACTED] and indicated: 1) sent email with reference request on both 11/27/2018 and 12/15/2018; 2) NC Medicaid planned to complete scoring by January 11, 2019; 3) would like to consider all information including this reference; 4) that a follow up email with the request & survey would be sent; and 5) contact information for Kimberley Kilpatrick in the event there were questions.	N/A – Re
[REDACTED]	11/27/2018	N/A – Returned 12/13/2018	N/A	N/A
[REDACTED]	11/27/2018	N/A – Returned 11/28/2018	N/A	N/A

Attachment #4 PHP Evaluation Committee Meeting Notes and Timeline

AmeriHealth				
Delaware Department of Health and Social Services (DHSS), Division of Medicaid and Medical Assistance	11/27/2018	12/15/2018	N/A -Returned 12/17/2018	N/A
Louisiana Department of Health (LDH)	11/27/2018	12/15/2018	N/A – Returned 12/21/2018	N/A
Michigan Department of Health and Human Services (MDHHS)	11/27/2018	N/A – Returned 12/14/2018	N/A	N/A
South Carolina Department of Health and Human Services (SCDHHS)	11/27/2018	12/15/2018	01/03/2019 Left message with Bryan Amick (803-898-0212) and indicated: 1) sent email with reference request on both 11/27/2018 and 12/15/2018; 2) NC Medicaid planned to complete scoring by January 11, 2019; 3) would like to consider all information including this reference ; 4) that a follow up email with the request & survey would be sent: and 5) contact information for Kimberley Kilpatrick in the event there were questions.	N/A – Ret

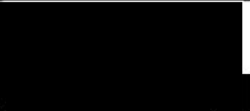


Attachment #4 PHP Evaluation Committee Meeting Notes and Timeline

BCBS of NC Healthy Blue				
AMGP Georgia Managed Care Company, Inc. (Amerigroup Georgia) as an affiliate of their subcontractor, Amerigroup Partnership Plan, LLC	11/27/2018	12/15/2018	01/03/2019 Left message with Blake Fulenwider (404-657-7739) and indicated: 1) sent email with reference request on both 11/27/2018 and 12/15/2018; 2) NC Medicaid planned to complete scoring by January 11, 2019; 3) would like to consider all information including this reference ; 4) that a follow up email with the request & survey would be sent: and 5) contact information for Kimberley Kilpatrick in the event there were questions.	01/16/2019 requesting 9:00 AM 0 be considered Reference could not
Amerigroup Partnership Plan, LLC subcontract with BlueChoice Health Plan of South Carolina, Inc.	11/27/2018	12/15/2018	N/A – Returned 12/17/2018 but not scored as it was not considered to be an acceptable Client Reference because it came from BlueChoice HealthPlan of South Carolina and not the state of South Carolina.	1/22/2019 After qual references that the re BlueChoice Carolina sh consistent other client

Attachment #4 PHP Evaluation Committee Meeting Notes and Timeline

AMERIGROUP Washington, Inc. as an affiliate of their subcontractor, Amerigroup Partnership Plan, LLC	11/27/2018	12/15/2018	01/03/2019 Left message with Preston Cody (360-725-1786) and indicated: 1) sent email with reference request on both 11/27/2018 and 12/15/2018; 2) NC Medicaid planned to complete scoring by January 11, 2019; 3) would like to consider all information including this reference; 4) that a follow up email with the request & survey would be sent: and 5) contact information for Kimberley Kilpatrick in the event there were questions. As P. Cody was a reference for both BCBS and United HealthCare, the message and email sent 01/03/2019 included follow up for both BCBS and United HealthCare to avoid multiple messages and emails.	01/16/2019 requesting 9:00 AM O be consid Reference could not
AMERIGROUP Maryland, Inc. (AMERIGROUP Maryland) as an affiliate of their subcontractor, Amerigroup Partnership Plan, LLC	11/27/2018	N/A – Returned 12/6/2018	N/A	N/A

Attachment #4 PHP Evaluation Committee Meeting Notes and Timeline

Carolina Complete Health				
Granite State Health Plan, Inc. (d/b/a., NH Healthy Families), as an affiliate of Carolina Complete Health, Inc.	11/27/2018	12/15/2018	N/A – Returned 12/16/2018	N/A
Managed Health Services, Inc. (MHS), as an affiliate of Carolina Complete Health, Inc.	11/27/2018	N/A – Returned 12/7/2018	N/A	N/A
Sunflower Health Plan, Inc., as an affiliate of Carolina Complete Health, Inc.	11/27/2018	N/A – Returned 12/11/2018	N/A	N/A
Superior HealthPlan, Inc. (Texas)	11/27/2018	N/A – Returned 11/29/2018	N/A	N/A
My Health by Health Providers				
	11/27/2018	N/A – Returned 11/27/2018	N/A	N/A
	11/27/2018	N/A – Returned 12/13/2018	N/A	N/A
	11/27/2018	N/A – Returned 12/7/2018	N/A	N/A

Attachment #4 PHP Evaluation Committee Meeting Notes and Timeline

Only provided three (3) client references in response				
Optima				
Department of Medical Assistance Services – PACE	11/27/2018	12/15/2018	01/03/2019 Left message with Barbara McCray (804-225-4385) and indicated: 1) sent email with reference request on both 11/27/2018 and 12/15/2018; 2) NC Medicaid planned to complete scoring by January 11, 2019; 3) would like to consider all information including this reference ; 4) that a follow up email with the request & survey would be sent: and 5) contact information for Kimberley Kilpatrick in the event there were questions.	01/16/2019 requesting 9:00 AM 0 be considered Reference could not
Huntsville Hospital Health System	11/27/2018	N/A – Returned 12/3/2018, not scored as reference indicated the services were never implemented as contract/project canceled.	N/A	N/A
Department of Medical Assistance Services - Operations	11/27/2018	N/A – Returned 12/12/2018	N/A	N/A

Attachment #4 PHP Evaluation Committee Meeting Notes and Timeline

Department of Medical Assistance Services – Integrated Care	11/27/2018	N/A – Returned 11/28/2018	N/A - Returned	N/A - retu
United HealthCare				
Michigan Department of Health and Human Services	11/27/2018	N/A – Returned 12/14/2018	N/A	N/A
Health Care Authority – Health Care Services	11/27/2018	12/15/2018	01/03/2019 Left message with Preston Cody (360-725-1786) and indicated: 1) sent email with reference request on both 11/27/2018 and 12/15/2018; 2) NC Medicaid planned to complete scoring by January 11, 2019; 3) would like to consider all information including this reference; 4) that a follow up email with the request & survey would be sent: and 5) contact information for Kimberley Kilpatrick in the event there were questions. As P. Cody was a reference for both BCBS and United HealthCare, the message and email sent 1/3/2019 included follow up for both BCBS and United HealthCare to avoid multiple messages and emails.	01/16/2019 requesting 9:00 AM 0 be consid Reference could not

Attachment #4 PHP Evaluation Committee Meeting Notes and Timeline

Rhode Island Executive Office of Health and Human Services	11/27/2018	N/A – Returned 12/11/2018	N/A	N/A
Kansas Department of Health and Environment Resources (KDHE)	11/27/2018	N/A – Returned 11/28/2018	N/A	N/A
WellCare				
WellCare of Georgia, Inc. (WCGA), as an affiliate of WellCare of North Carolina, Inc.	11/27/2018	12/15/2018	01/03/2019 Left message with Blake Fulenwider (404-657-7739) and indicated: 1) sent email with reference request on both 11/27/2018 and 12/15/2018; 2) NC Medicaid planned to complete scoring by January 11, 2019; 3) would like to consider all information including this reference; 4) that a follow up email with the request & survey would be sent: and 5) contact information for Kimberley Kilpatrick in the event there were questions.	01/16/2019 requesting 9:00 AM 0 be considered Reference could not

Attachment #4 PHP Evaluation Committee Meeting Notes and Timeline

WellCare of Kentucky, Inc. (WCKY), as an affiliate of WellCare of North Carolina, Inc.	11/27/2018	12/15/2018	01/03/2019 - Jill Hunter referred to Stephanie Bates and did not provide contact info. Left a message with Hunter on 01/03/2019. Using the company directory, located a Stephanie Bates at ext. 2112 and left message for Bates. Sent follow up email to Hunter requesting additional contact info for Bates. Using the first.last@ky.gov format sent to Stephanie.Bates@ky.gov hoping to be received or bounce back. No follow up from Hunter or Bates.	01/16/2019 requesting 9:00 AM 0 be considered. Returned scored.
WellCare of New Jersey, Inc. (WCNJ), as an affiliate of WellCare of North Carolina, Inc.	11/27/2018	12/15/2018	01/03/2019 – Called <insert name – Grant> at <insert #> and spoke with Paula Kamrad (Grant’s assistant). Resent request and survey copying Ms. Kamrad.	N/A – Ret
WellCare of Florida, Inc., d/b/a. Staywell Health Plan of Florida (Staywell)	11/27/2018	N/A – Returned 12/4/2018	N/A	N/A

EXHIBIT B

RFP #30-190029-DHB - Prepaid Health Plans

Highest Scoring Offer, Ranked 1st	736.19304	71.824%
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Difference vs Rank

Type of Contract	Rank	Offeror Name	Weighted Total Score	Percentage of Total Possible Points	# Points	% F
Statewide	1		736.19304	71.824%	0.00000	
Statewide	2		727.76474	71.001%	-8.42830	
Statewide	3		712.22431	69.485%	-23.96873	
Statewide	4		706.66204	68.943%	-29.53100	
Statewide	5		704.60144	68.742%	-31.59160	
Statewide	6		629.71280	61.435%	-106.48024	-1
Either	7		628.39969	61.307%	-107.79335	-1
Regional	8		573.48539	55.950%	-162.70765	-1

Total Possible Score	1025.00000
Total Possible If All Scores Meet Expectations (60%)	615.00000

Offeror is a PLE
Offeror did not achieve average score of Meets

RFP #30-190029-DHB - Prepaid Health Plans

Highest Scoring Offer, Ranked 1st					736.19304		71.824%	
					Difference vs Ranked 1st			
Type of Contract	Rank	Offeror Name	Weighted Total Score	Percentage of Total Possible Points	# Points	% Points		
Statewide	1	WellCare Health Plans	736.19304	71.824%	0.00000	0.00000		
Statewide	2	United Health Care	727.76474	71.001%	-8.42830	-0.823%		
Statewide	3	BCBSNC – Healthy Blue	712.22431	69.485%	-23.96873	-2.337%		
Statewide	4	AmeriHealth Caritas North Carolina	706.66204	68.943%	-29.53100	-2.884%		
Statewide	5	Aetna	704.60144	68.742%	-31.59160	-3.082%		
Statewide	6	My Health by Health Providers	629.71280	61.435%	-106.48024	-10.389%		
Either	7	Carolina Complete Health	628.39969	61.307%	-107.79335	-10.511%		
Regional	8	Optima Health	573.48539	55.950%	-162.70765	-15.875%		
Total Possible Score			1025.00000					
Total Possible If All Scores Meet Expectations (60%)			615.00000					
Offeror is a PLE								
Offeror did not achieve average score of Meets								

RFP #30-190029-DHB - Prepaid Health Plans

Offeror Name	Aetna	AmeriHealth Caritas North Carolina	BCBSNC – Healthy Blue	Carolina Complete Health	My He He Prov
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Proposal Evaluation Sub Criteria from Section II. Table 3	Attachment O: Offeror's Proposal and Response Section 3 Evaluation Questions Section	Proposal Evaluation Criteria Weights from Section II. Table 3	Proposal Evaluation Sub Criteria Sub Weights for Scope of Services from Section II. Table 3	Weighting for Evaluation Question Sections	Maximum Available Points per Section	Evaluation Question #	Weighted Score	Weighted Score	Weighted Score	Weighted Score	Weighted Score
	Offeror Qualifications & Experience	20%			200.00000	1 - 10	172.82500	164.72923	157.08500	126.85500	155.8
a) Develop, implement and sustain the organizational, operational, technical and administrative functions and capabilities to reliably serve as an effective partner in delivering Medicaid Managed Care to North Carolinians.	Administration & Management	70%	7.5%	50.0%	26.25000	12 - 19	17.94844	17.62031	19.26094	15.09375	16.8
	Program Operations			25.0%	13.12500	50 - 54	9.05625	9.18750	8.53125	7.87500	7.6
	Other			25.0%	13.12500	64 - 65	11.15625	7.87500	7.87500	8.95781	7.8
b) Improve the likelihood of better health outcomes by enhancing the Member experience through promoting Member rights, engaging Members through health education, providing optimal customer service and support, and delivering services in a culturally competent manner.	Members		15%		105.00000	20 - 24	67.65938	62.31750	68.23688	70.08750	62.8
c) Develop coordinated programs and services that deliver health through whole-person care, comprehensive care management, improve population health, and provide programs and services addressing healthy opportunities.	Benefits & Care Management		25%		175.00000	25 - 39	116.48000	110.12750	120.41750	99.38250	107.9
d) Develop and maintain a robust provider network that maintains strong provider and community participation and demonstrates an understanding of the health needs of the North Carolina population to ensure available, accessible, high quality care and services are delivered to all Members.	Providers		15%		105.00000	40 - 44	70.61250	66.15000	69.01125	65.10000	61.2
e) Develop a comprehensive quality improvement and value-based purchasing approach to drive the Department's overall vision for advancing and measuring high-value care.	Quality & Value		15%		105.00000	45 - 46	63.00000	89.25000	89.25000	63.00000	50.4
f) Engage and integrate key Department partners and stakeholders including tribal populations, county agencies, community-based organizations, other managed care program entities, and Department partners to support North Carolina's Medicaid Managed Care goals.	Stakeholder Engagement		7.5%		52.50000	47 - 49	31.50000	31.50000	31.50000	31.50000	32.4
g) Promote and monitor North Carolina's Medicaid Managed Care sustainability by developing the processes, standards, and data protocols needed to demonstrate good financial stewardship of limited resources and adherence to financial management objectives.	Claims and Encounter Management		10%	50%	35.00000	55 - 56	21.05863	21.00000	17.95150	22.46563	19.3
	Financial Requirements			50%	35.00000	57 - 59	20.05500	20.05500	21.63000	19.58250	21.6
h) Promote a culture of compliance through comprehensive oversight and program integrity strategies aligned with industry best practices and compliant with federal and state law and regulation.	Compliance		5%		35.00000	60 - 63	24.50000	22.75000	21.00000	21.00000	21.0
	Use Cases	5%			50.00000	Scenarios #1 - #7	30.00000	30.35000	30.47500	30.00000	27.2
	Client References	5%			50.00000	Client References #1 - #4	48.75000	48.75000	25.00000	42.50000	37.5
	Subtotal Score	100%	100%		1000.00000		704.60144	701.66204	687.22431	623.39969	629.1
	Bonus Points	2.5%			25.00000	11	0.00000	5.00000	25.00000	5.00000	0.0
	Total Score	102.5%			1025.00000		704.60144	706.66204	712.22431	628.39969	629.1

Proposal Evaluation Criteria from Section 8, Table 3	Proposal Evaluation Sub Criteria from Section 8, Table 3	Attachment O: Offeror's Proposal and Response Section 3 Evaluation Questions Section	Proposal Evaluation Criteria Weights from Section 8, Table 3	Proposal Evaluation Sub Criteria Sub Weights for Scope of Services from Section 8, Table 3	Weighting for Evaluation Questions Sections	Maximum Available Points per Question Section	Question Weights	Question Sub Weights	Maximum Available Points per Question	Evaluation Question #	Evaluation Question	Evaluation Question Sub Component	Consensus Score	Offeror Weighted Score	Scoring Guide	Comments	Scoring Options
							15%		7.50000	Scenario #7	The Offeror must describe how it would assess the quality of Dr. Xavier's practice. At minimum, the Offeror shall address the following to be response: a. Network Adequacy b. Provider Competency c. Provider Support d. Cultural Competency; and e. Community Engagement.	Exceeds		6.37500	Use the 5-rating scale.	Response demonstrates a very good understanding and provides a comprehensive approach detailing a timeline for [REDACTED]	Substantially Exceeds Expectations Exceeds Needs Partially Meets Does Not Meet
4. CLIENT REFERENCES	N/A	Client References	5%			50.0000	25%	75%	9.37500	Client Reference #1	Relevant to Scope of this RFP	Yes		9.37500	Error requested information in columns 5 through X about client [REDACTED]	Yes	Yes
								25%	3.12500	Client Overall Satisfaction	Very Satisfied	3.12500		Very Satisfied Yes	Very Satisfied Yes		
								75%	9.37500	Client Reference #2	Relevant to Scope of this RFP	No	0.00000	Error requested information in columns 5 through X about client reference	Reference not returned and could not be considered. See Contract File for supporting documentation.	Yes	Yes
								25%	3.12500	Client Overall Satisfaction	No	0.00000		Very Satisfied Satisfied	Very Satisfied Satisfied		
								75%	9.37500	Client Reference #3	Relevant to Scope of this RFP	Yes	9.37500	Error requested information in columns 5 through X about client		Yes	Yes
								25%	3.12500	Client Overall Satisfaction	Very Satisfied	3.12500		Very Satisfied Satisfied	Very Satisfied Satisfied		
								75%	9.37500	Client Reference #4	Relevant to Scope of this RFP	No	0.00000	Error requested information in columns 5 through X about client reference	Reference not returned and could not be considered. See Contract File for supporting documentation.	Yes	Yes
								25%	3.12500	Client Overall Satisfaction	No	0.00000		Very Satisfied Satisfied	Very Satisfied Satisfied		
Bonus Points Table																	
5. BONUS POINTS: Marketplace Participation	N/A	Subtotal Score Bonus Points	100% 2.5%	100%		1,000.0000 25.0000	100%	20%	100.0000 5.00000	11	The Department is seeking partners to participate in FFM in QHP Year 2021 in North Carolina? The Offeror may choose, at its sole discretion, to indicate its commitment to offer Qualified Health Plans (QHPs) in North Carolina on the Federally Facilitated Marketplace (FFM) in QHP Year 2021. Commitment to offer QHPs in the FFM is defined as timely submitting all necessary NCDCI-related regulatory submissions (including rules and policy terms) and QHP application to the FFM in the Spring of 2020 or within whatever time frame NC DCI and the FFM requires, and continuing to submit such all required state and federal approvals to offer QHPs. The Offeror may choose to indicate its commitment to participating in the FFM by outlining current Marketplace participation in North Carolina and	Yes		687.22431 0.00000	See detailed excel tool for Bonus Question #11	Yes	Yes
							40%	10.00000	Addressing chosen goal	Error # of proposed NC FFM courtesies in proposed PMP region	100		10.00000			Error # of proposed NC FFM courtesies in proposed PMP region	
							40%	10.00000	Addressing competition goal	Error # of proposed PMP courtesies in proposed NC FFM Error # of enrolled NC FFM members* in proposed NC FFM Error # of enrolled NC FFM members*	100 51003 51003		10.00000			Error # of proposed PMP courtesies Error # of enrolled NC FFM members* in proposed NC FFM courtesies	
																	Error # of enrolled NC FFM members*
		Total Score	102.5%			1025.00000			1025.00000						712.22431		

EXHIBIT C

IN THE OFFICE OF ADMINISTRATIVE HEARINGS

Optima Family Care of North Carolina,
Inc.,

COUNTY of WAKE

Petitioner,

19 DHR 01959

v.

North Carolina Department of Health
and Human Services, Mandy Cohen M.D.,
MPH in her official capacity as
Secretary of the Department and Dave
Richard in his official capacity as
Deputy Secretary of the Department of
NC Medicaid,

Respondents,

and

WellCare of North Carolina, Inc.,
Blue Cross and Blue Shield of North
Carolina, AmeriHealth Caritas of
North Carolina, Inc., Carolina
Complete Health, Inc.,

Respondent-Intervenors.

(Captions continued on page 2)

VOLUME IV

30(b)(6) Deposition of the
North Carolina Department of Health and Human Services
by and through its agency or representative,
Kimberley Kilpatrick

August 27, 2019

Reporter: Cynthia W. Rice
WORDSERVICES, INC.
1102 Driftwood Drive
Siler City, North Carolina 27344
919.548.4914
wanda@mywordservices.com

North Carolina Provider Owned Plans,
 Inc., d/b/a My Health by Health
 Providers,
 Petitioner,

COUNTY of WAKE
 19 DHR 02032

v.

North Carolina Department of Health
 and Human Services,
 Respondent,

and

UnitedHealthcare of North Carolina,
 Inc., Blue Cross and Blue Shield of
 North Carolina, WellCare of North
 Carolina, Inc., AmeriHealth Caritas
 of North Carolina, Inc., Carolina
 Complete Health, Inc.,
 Respondent-Intervenors.

Aetna Better Health of North
 Carolina, Inc. d/b/a Aetna Better
 Health of North Carolina,
 Petitioner,
 v.

COUNTY of WAKE
 19 DHR 02194

State of North Carolina Department of
 Health and Human Services,
 Respondent,
 and

WellCare of North Carolina, Inc.,
 Blue Cross and Blue Shield of North
 Carolina, AmeriHealth Caritas of
 North Carolina, Inc.,
 UnitedHealthcare of North Carolina,
 Inc., Carolina Complete Health, Inc.,
 Respondent-Intervenors.

(Captions continued on page 3)

Carolina Complete Health, Inc., COUNTY of WAKE

Petitioner, 19 DHR 03352

v.

North Carolina Department of Health
and Human Services,
Respondent.

VOLUME IV

30(b)(6) Deposition of the
North Carolina Department of Health and Human Services
by and through its agency or representative
Kimberley Kilpatrick

August 27, 2019

9:03 a.m.

Pages 575 - 836

Law Offices of

Wyrick Robbins Yates & Ponton, L.L.P.

4101 Lake Boone Trail, Suite 300

Raleigh, North Carolina 27607

1 second. But the evaluation committee's job was to provide
2 ratings, which we've been calling scores, but they're
3 really ratings subject to the directions of the scoring
4 guide. Is that correct?

5 A. That is correct.

6 Q. Based upon the information provided, et cetera.
7 But it was the scoring guide that said here you apply the
8 five-level rating or here you apply a three-level rating or
9 here you just say yes or no, correct?

10 MS. JOSEPH: Objection to form.

11 A. Correct.

12 BY MR. PURYEAR:

13 Q. And the actual points that would be awarded per
14 question were not known by the evaluation committee --

15 A. That is correct.

16 Q. -- until the end. When they finally saw the
17 final scores they could -- did they have the opportunity
18 once the final scores were provided to them to go back and
19 see what each question was weighted?

20 MR. ALEXANDER: Objection to form.

21 A. The evaluation committee was presented -- I
22 believe it's the summary page of that that shows where the
23 different offerors fell within the points for like the
24 quality assurance section. The evaluation committee was
25 not -- there was not a discussion of "Within the Excel

1 spreadsheet, these are the points that were awarded for
2 each thing."

3 There was again when we talked about the
4 references. Because when the points were revealed on the
5 initial reveal, there was a discussion on the Blue Cross
6 Blue Shield and Aetna because there was a difference in
7 points based on the Blue Cross Blue Shield reference not
8 being scored.

9 And the evaluation committee asked at that point,
10 what is the points for a reference? And it is worth 12 and
11 a half points of the total score, which is where the
12 evaluation committee looked at that and said a reference --
13 a reference is making the difference in fourth place and
14 fifth place.

15 And at that point Ms. Moon, over the weekend,
16 looked in more detail about that reference. And that's
17 when on the 22nd -- on the 22nd she brought it back and we
18 talked about the reference and as to -- let me make sure it
19 was the 22nd -- yes, and as to whether that should be
20 scored given it had not been scored previously.

21 BY MR. PURYEAR:

22 Q. And that's 12 points out of 1,025, right?

23 A. 12 and a half points out of 1,025.

24 Q. So roughly just north of 1 percent of the total
25 score, right?

1 A. (No response.)

2 Q. So looking at the actual final scores that got
3 awarded on page 23, we have a difference of certainly less
4 than 12 points between fourth and fifth place, correct?

5 A. Correct.

6 Q. And then there's certainly less than a 12-point
7 difference between My Health and Carolina Complete Health.
8 Is that right?

9 A. Correct.

10 Q. And to be clear, Mr. Wolfe harped on the fact
11 that in section 6. on page 22 it said:

12 "Awarding a contract to CCH would result in
13 making an award over higher scoring and more
14 technically capable Offerors."

15 The only two entities that scored above Carolina
16 Complete Health but didn't get a recommendation of an award
17 were Aetna and My Health. Is that right?

18 MR. WOLFE: Objection.

19 A. Will you restate the question? I'm sorry. He
20 hasn't objected yet, so --

21 BY MR. PURYEAR:

22 Q. That's okay. It was a very forceful objection
23 too. He was focusing on the fact that in section 6. it
24 says:

25 "Awarding a contract to CCH would result in

EXHIBIT D

IN THE OFFICE OF ADMINISTRATIVE HEARINGS

Optima Family Care of North Carolina,
Inc.,

Petitioner,

COUNTY of WAKE

19 DHR 01959

v.

North Carolina Department of Health
and Human Services, Mandy Cohen M.D.,
MPH in her official capacity as
Secretary of the Department and Dave
Richard in his official capacity as
Deputy Secretary of the Department of
NC Medicaid,

Respondents,

and

WellCare of North Carolina, Inc.,
Blue Cross and Blue Shield of North
Carolina, AmeriHealth Caritas of
North Carolina, Inc., Carolina
Complete Health, Inc.,

Respondent-Intervenors.

(Captions continued on page 2)

VOLUME II

DEPOSITION OF AMANDA VAN VLEET

September 4, 2019

Reporter: Elaine F. Hayes, Court Reporter
WORDSERVICES, INC.
1102 Driftwood Drive
Siler City, North Carolina 27344
919.548.4914
wanda@mywordservices.com

North Carolina Provider Owned Plans,
Inc., d/b/a My Health by Health
Providers,
Petitioner,

COUNTY of WAKE
19 DHR 02032

v.

North Carolina Department of Health
and Human Services,
Respondent,

and

UnitedHealthcare of North Carolina,
Inc., Blue Cross and Blue Shield of
North Carolina, WellCare of North
Carolina, Inc., AmeriHealth Caritas
of North Carolina, Inc., Carolina
Complete Health, Inc.,
Respondent-Intervenors.

Aetna Better Health of North
Carolina, Inc. d/b/a Aetna Better
Health of North Carolina,
Petitioner,
v.

COUNTY of WAKE
19 DHR 02194

State of North Carolina Department of
Health and Human Services,
Respondent,
and

WellCare of North Carolina, Inc.,
Blue Cross and Blue Shield of North
Carolina, AmeriHealth Caritas of
North Carolina, Inc.,
UnitedHealthcare of North Carolina,
Inc., Carolina Complete Health, Inc.,
Respondent-Intervenors.

(Captions continued on page 3)

Carolina Complete Health, Inc., COUNTY of WAKE
Petitioner, 19 DHR 03352

v.

North Carolina Department of Health
and Human Services,
Respondent.

DEPOSITION OF AMANDA VAN VLEET

VOLUME II

Pages 62 - 374

September 4, 2019

9:00 a.m.

Law Offices of

Wyrick Robbins Yates & Ponton, L.L.P.

4101 Lake Boone Trail, Suite 300

Raleigh, North Carolina 27607

1 Q. And you were hired when?

2 A. My first day with the Department was in early
3 October of last year.

4 Q. Do you recall the first day, approximately?

5 A. No. Gosh, around October 8th or so.

6 Q. Gotcha. So within the first week or so of
7 October?

8 A. Yes.

9 Q. And before starting this particular position and
10 accepting your role on the evaluation committee, you filled
11 out a conflicts form. Do you remember that?

12 A. Yes.

13 Q. Okay. And on that conflicts form, did you -- with
14 regard to that conflicts form, did you understand the
15 purpose of it?

16 A. Generally, yes.

17 Q. Tell me your general understanding.

18 A. The form was to indicate that I had -- my
19 understanding of the form was to indicate that I had no
20 conflict of interest that would inhibit my ability to score
21 and evaluate fairly to be on the evaluation committee.

22 Q. Did you complete that form as best as you could?

23 A. Yes.

24 Q. Did you identify in that form that you had a
25 boyfriend at Blue Cross Blue Shield?

1 A. Not in the form, but I had spoken to Jay Ludlam to
2 let him know that when he told me that he wanted me to be on
3 the evaluation committee.

4 Q. Okay. You knew that question was coming. Fair?

5 A. I did.

6 Q. And when you spoke to Jay Ludlam, do you know what
7 date that was?

8 A. That was before I started working, during my
9 interview process.

10 Q. So in the interview process you advised Mr. Ludlam
11 that you were dating a gentleman from Blue Cross Blue
12 Shield, correct?

13 A. Yes, yes.

14 Q. Okay. And that would have been sometime -- well,
15 strike that.

16 When would you have interviewed with Mr. Ludlam?

17 A. My conversations with him lasted a couple of
18 months, but this conversation was probably in September.

19 Q. So when you told Mr. Ludlam -- well, strike that.

20 Did you tell Mr. Ludlam that you were dating
21 somebody from Blue Cross Blue Shield out of concern for the
22 conflicts?

23 A. Yes. When he asked me to be on the evaluation
24 committee, I was concerned about a potential conflict and
25 that it may arise, and so I let him know that I was dating

1 someone at Blue Cross, told him a little bit about his role.
2 And he said he would check with some others and get back to
3 me, and he said that -- he asked me if I believed that I
4 could score fairly, and I said yes.

5 And he said, "Okay, then we don't have a problem
6 with you being on the evaluation committee and signing the
7 conflict of interest form."

8 Q. But you never listed it on your conflicts of
9 interest form, correct?

10 A. I don't remember there being a place for me to
11 list potential conflicts.

12 Q. Did you consider it to be a conflict?

13 A. No.

14 Q. A potential conflict?

15 A. Well, when I first raised it. But after hearing
16 that it wasn't a concern with people higher up, then I
17 believed in my ability to score accurately and fairly.

18 Q. And did Mr. Ludlam tell you who he checked with?

19 A. He said he was going to check with legal, as I
20 remember.

21 Q. Do you know if he shared the same with Secretary
22 Cohen?

23 A. I don't know.

24 Q. Did you ever ask him?

25 A. No.

1 Q. Did you ever ask him who he spoke with in legal as
2 to whether or not your dating someone from Blue Cross Blue
3 Shield would in fact be a conflict or a potential conflict?

4 MR. KNOWLTON: Objection to the extent it seeks
5 legal privileged advice.

6 BY MR. KESSLER:

7 Q. Did you understand the question?

8 A. I didn't ask. I didn't ask him.

9 Q. Okay. Did you ever have any discussions with
10 legal about it?

11 A. No, no.

12 Q. Did you ever have discussions with anybody else at
13 the Department concerning the potential conflict?

14 A. I let Kimberley Kilpatrick know during --

15 Q. And when did you do that?

16 A. I can't remember when exactly I first mentioned it
17 but early on in the evaluation committee review process.

18 Q. So after you already started the evaluation
19 process?

20 A. Yes.

21 Q. Do you know how far in?

22 A. Early in the first week or so, I would imagine.

23 Q. Did you pull her aside to tell her, or did you
24 have this communication in writing?

25 A. It was verbal. I pulled her aside.

1 Q. Okay. And at least in your mind, it was important
2 for you to share that with Ms. Kilpatrick, correct?

3 A. Yes.

4 Q. That's why you raised it?

5 A. Yes.

6 Q. All right. And that's also why you raised it with
7 regard to Mr. Ludlam, correct?

8 A. Yes.

9 Q. But it was still, again, not to your -- to your
10 recollection, it was not on the conflict sheet that you
11 signed, correct --

12 A. Correct.

13 Q. -- and identified.

14 When you spoke to Ms. Kilpatrick, what did you
15 tell her?

16 A. I let her know that I was dating someone at Blue
17 Cross, that I had talked to Jay, that he had talked to
18 legal, that they had told me that it was okay, and basically
19 just wanted her to be aware.

20 Q. All right. Did she ask you any questions?

21 A. The only question I remember her also asking is if
22 I could -- if I believed that I could evaluate fairly.

23 Q. Had you ever evaluated previously?

24 A. No.

25 Q. So how do you know whether or not you could

1 evaluate fairly if you've never done it before under the
2 circumstances?

3 A. Well --

4 MR. KNOWLTON: Objection to form.

5 MS. MANDEVILLE: Objection to form.

6 A. We do new things every day.

7 BY MR. KESSLER:

8 Q. I understand.

9 A. I'm a professional adult. I believe that I was
10 able to evaluate fairly.

11 Q. All right. And what you're saying is, you believe
12 that you are able to separate your personal interests with
13 that of the interests that you were being asked to address
14 on behalf of the State of North Carolina?

15 A. Yes.

16 MR. KNOWLTON: Objection to form.

17 MS. MANDEVILLE: Objection to form.

18 MS. CROWLEY: Objection.

19 BY MR. KESSLER:

20 Q. Can you tell me what your understanding is of a
21 conflict of interest?

22 A. My understanding of a conflict of interest would
23 be, one, anything that may prohibit me from evaluating
24 fairly and be in discussions with someone at a party that
25 should not be happening because those conversations should

1 be confidential.

2 Q. Anything else that you understand to be a conflict
3 of interest?

4 A. That's how I -- those are the two main things.
5 That's how I understand it.

6 Q. And when you spoke to Ms. Kilpatrick and you spoke
7 to Mr. Ludlam, did either one of them advise you that you
8 should place that information on your conflict form?

9 A. No.

10 Q. Did you ever go back and amend your conflict form?

11 A. No.

12 Q. When you presented this to Mr. Ludlam, how long
13 had you been dating with your boyfriend from Blue Cross Blue
14 Shield?

15 A. About a year.

16 Q. And can you tell us what position he holds with
17 Blue Cross Blue Shield?

18 A. Yes. I believe it's director of health care
19 strategy and transformation.

20 Q. I'm sorry. Director of health care strategy and?

21 A. And transformation.

22 Q. And transformation. And so he does deal with
23 Medicaid services. Is that correct?

24 MR. GATES: Objection to form.

25 A. Not directly. He -- his portfolio spans all

1 payors, but he does not have any decision-making
2 authority -- authority over Medicaid. And they have a
3 separate Medicaid team that he is not on, so he doesn't have
4 any direct impact on decision-making on Medicaid.

5 BY MR. KESSLER:

6 Q. Would you agree with me that he has indirect
7 contact with those in Medicaid as a result of his position?

8 MR. KNOWLTON: Object to form.

9 MR. GATES: Object to form.

10 A. Sure.

11 BY MR. KESSLER:

12 Q. Did you ever tell -- did you ever tell your
13 boyfriend what position you were accepting when you decided
14 to come to the State of North Carolina board?

15 A. Yes.

16 Q. Did you tell him your title?

17 A. Yes.

18 Q. Did you tell him what the duties and
19 responsibilities would be?

20 A. Yes.

21 Q. Did you tell him that you would be serving at the
22 evaluation committee?

23 A. Yes.

24 Q. Did you explain what the evaluation committee was
25 asked to perform, what they were asked to do?

1 A. Yes.

2 Q. Did you tell him -- did he have an understanding
3 at any time as to who the offerors were?

4 A. Only when they were made public on our website.

5 Q. All right. At any time prior to them becoming
6 public, did -- can you tell me whether you have an
7 understanding as to whether he knew that Blue Cross Blue
8 Shield was making -- had submitted an offer?

9 A. Yes, he was aware.

10 Q. Had you ever been to his office before?

11 A. No, I don't believe so. If so, only to drop him
12 off at the -- at the entrance.

13 Q. I understand. Where does he work?

14 A. His office is in Durham.

15 Q. Was that one of the reasons for coming here to
16 North Carolina --

17 A. One of them.

18 Q. -- from Washington, D.C.?

19 A. Yes.

20 Q. And it's fair to say that you would be social with
21 him with folks from -- who he worked with that were at Blue
22 Cross Blue Shield?

23 MR. GATES: Objection to form.

24 MS. MANDEVILLE: Objection to form.

25 A. Not during the evaluation committee. I actually

1 made a conscious effort to not see or meet anyone that he
2 worked with during that process.

3 BY MR. KESSLER:

4 Q. Did anyone tell you to do that?

5 A. Yeah. Well, people from the Department had
6 recommended that, I believe.

7 Q. Who at the Department recommended that?

8 A. I can't remember specifically.

9 Q. So there was others besides Mr. Ludlam and
10 Ms. Kilpatrick who knew that you were dating somebody from
11 Blue Cross Blue Shield?

12 A. I mentioned it. I mean, I didn't keep it a
13 secret.

14 Q. Who else did you mention it to?

15 A. My supervisor.

16 Q. Who is that?

17 A. Her name is Kelly Crosbie. I can't remember who
18 else specifically.

19 Q. You said there was others in addition to
20 Ms. Crosbie, but as we sit here today, you just don't
21 recollect. Is that your testimony?

22 A. Yes.

23 Q. All right. When you advised Ms. Crosbie, do you
24 know when that was?

25 A. Early on when I started. As someone who moved to

EXHIBIT E

North Carolina Department of Health
and Human Services, Mandy Cohen,
M.D., MPH, in her official capacity as
Secretary of the Department, and Dave
Richard in his official capacity as Deputy
Secretary of the Department
for NC Medicaid,

Respondent,

And

WellCare of North Carolina, Inc.,
Blue Cross And Blue Shield of North
Carolina, AmeriHealth Caritas of North
Carolina, Inc., UnitedHealthCare of
North Carolina, Inc., and Carolina
Complete Health, Inc.,

Respondent-Intervenors.

19 DHR 01959

North Carolina Provider Owned Plans,
Inc. d/b/a My Health By HealthProviders,
Petitioner,

v.

North Carolina Department of Health
and Human Services,

Respondent,

And

UnitedHealthCare of North Carolina,
Inc., Blue Cross And Blue Shield of North
Carolina, WellCare of North Carolina
Inc., AmeriHealth Caritas of North
Carolina, Inc., and Carolina Complete
Health, Inc.,

Respondent-Intervenors.

19 DHR 02032

<p>Respondent,</p> <p>And</p> <p>WellCare of North Carolina, Inc., Blue Cross And Blue Shield of North Carolina, AmeriHealth Caritas of North Carolina, Inc., UnitedHealthCare of North Carolina, Inc., Carolina Complete Health, Inc., Respondent-Intervenors.</p>	<p>19 DHR 02194</p>
<p>Carolina Complete Health, Inc., Petitioner,</p> <p>v.</p> <p>North Carolina Department of Health and Human Services, Respondent.</p>	<p>19 DHR 03352</p>

AFFIDAVIT OF MELISSA INMAN

Melissa Inman, being duly sworn, hereby deposes and says:

1. I am a citizen and resident of Wake County, North Carolina, over the age of eighteen, and competent to make this affidavit. I have actual knowledge of the matters and facts set forth in this affidavit.

3. Sheila Brabham Platts is employed by Blue Cross NC as a Team Leader, Product Analytics. She started in July, 2019.

4. Ms. Platts' responsibilities include leading a team that tests, certifies and supports analytics products and provides consulting and analysis of customer data and analytics issues.

5. The position which Ms. Platts now holds was advertised publicly by Blue Cross NC through a job posting on Blue Cross NC's external career website.

6. The salary range for the position of Team Leader, Product Analytics was established at the time of the posting, and it has not changed since that date. There was no signing bonus or any other up-front payment associated with the position.

7. Ms. Platts responded to the public posting of the position and was interviewed and ultimately offered the position with Blue Cross NC.

8. Ms. Platts does not have any responsibilities for projects related to North Carolina Medicaid.

Officer at Blue Cross NC. In June 2018, the area in which Mr. Sharp works was reorganized, and he became the Director of Healthcare Strategy and Transformation reporting to Troy Smith, the Vice President of Healthcare Strategy and Payment Transformation.

10. Mr. Sharp's responsibilities include leading a team that performs work relating to Blue Cross NC's approaches for reimbursement, quality measurement, population health management, and provider engagement.

11. Mr. Sharp's title contains the word "transformation." A simple Google search of the phrase "Healthcare Transformation" reveals that "transformation" is broadly used in healthcare. The term signals innovation in how health care is accessed, delivered, and paid for to improve health outcomes and tackle rising costs.

12. The fact that 'transformation' is in his title does not mean that his responsibilities are tied to North Carolina Medicaid Transformation. In fact, Mr. Sharp does not and has not had any direct responsibility for Blue Cross NC's North Carolina Medicaid operations.

FURTHER THE AFFIANT SAITH NOT.

[Signature on following page]

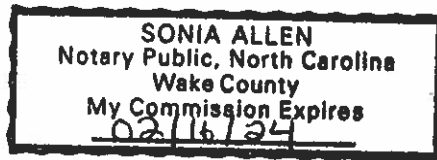
Melissa Inman

Durham COUNTY, NORTH CAROLINA

Signed and sworn to (or affirmed) before me this day by Melissa Inman.

Date: 10/31/2019

Sonia Allen
[Notary Signature]



Sonia Allen
[Printed Name]

My Commission Expires: 02/16/24

EXHIBIT F

IN THE OFFICE OF ADMINISTRATIVE HEARINGS

Optima Family Care of North Carolina,
Inc.,

COUNTY of WAKE

Petitioner,

19 DHR 01959

v.

North Carolina Department of Health
and Human Services, Mandy Cohen M.D.,
MPH in her official capacity as
Secretary of the Department and Dave
Richard in his official capacity as
Deputy Secretary of the Department of
NC Medicaid,

Respondents,

and

WellCare of North Carolina, Inc.,
Blue Cross and Blue Shield of North
Carolina, AmeriHealth Caritas of
North Carolina, Inc., Carolina
Complete Health, Inc.,

Respondent-Intervenors.

(Captions continued on page 2)

DEPOSITION OF SHEILA BRABHAM PLATTS

August 23, 2019

Reporter: Cynthia W. Rice, Court Reporter
WORDSERVICES, INC.
1102 Driftwood Drive
Siler City, North Carolina 27344
919.548.4914
wanda@mywordservices.com

North Carolina Provider Owned Plans,
Inc., d/b/a My Health by Health
Providers,
Petitioner,

COUNTY of WAKE
19 DHR 02032

v.

North Carolina Department of Health
and Human Services,
Respondent,

and

UnitedHealthcare of North Carolina,
Inc., Blue Cross and Blue Shield of
North Carolina, WellCare of North
Carolina, Inc., AmeriHealth Caritas
of North Carolina, Inc., Carolina
Complete Health, Inc.,
Respondent-Intervenors.

Aetna Better Health of North
Carolina, Inc. d/b/a Aetna Better
Health of North Carolina,
Petitioner,
v.

COUNTY of WAKE
19 DHR 02194

State of North Carolina Department of
Health and Human Services,
Respondent,
and

WellCare of North Carolina, Inc.,
Blue Cross and Blue Shield of North
Carolina, AmeriHealth Caritas of
North Carolina, Inc.,
UnitedHealthcare of North Carolina,
Inc., Carolina Complete Health, Inc.,
Respondent-Intervenors.

(Captions continued on page 3)

Carolina Complete Health, Inc., COUNTY of WAKE

Petitioner, 19 DHR 03352

v.

North Carolina Department of Health
and Human Services,
Respondent.

DEPOSITION OF SHEILA BRABHAM PLATTS

Pages 1 - 272

August 23, 2019

8:06 a.m.

Law Offices of

Wyrick Robbins Yates & Ponton, L.L.P.

4101 Lake Boone Trail, Suite 300

Raleigh, North Carolina 27607

1 THE WITNESS: Growth opportunity.

2 MR. PURYEAR: -- growth opportunities.

3 BY MR. PURYEAR:

4 Q. Did Blue Cross Blue Shield seek you out?

5 A. No, they did not.

6 Q. Did you seek them out?

7 A. Yes, I did.

8 Q. Did you see an ad for a particular position?

9 A. Yes, I did.

10 Q. And what position was that?

11 A. It is team lead in product analytics.

12 Q. And is that the position you have?

13 A. Yes, it is.

14 MR. KIVUS: I'm sorry. I just couldn't hear that
15 last part.

16 MR. PURYEAR: She's a team lead, product
17 analytics. And that is the position that she has.

18 MR. KIVUS: Thank you.

19 BY MR. PURYEAR:

20 Q. And you've been in that position for six weeks?

21 A. Yes.

22 Q. And as part of your -- or let me ask this. What
23 are your responsibilities as team leader, product analytics?

24 A. I'm responsible for data reporting.

25 Q. What does that mean?

1 are involved in the Medicaid management care contract with
2 the State of North Carolina?

3 A. Can you restate that question?

4 Q. Sure. And, again, I was just trying to think of a
5 better way -- better term to use than Chinese wall. But are
6 you -- were you told when you started work at Blue Cross
7 Blue Shield of North Carolina that you were not permitted to
8 work on implementation of the Medicaid managed care
9 contract?

10 A. Yes. I was informed that I would -- I knew going
11 in that I screened the position and it did not have any
12 Medicaid components related to it. And as a part of the
13 position now, I, as I previously stated, am not engaged in
14 any Medicaid work.

15 Q. So then tell me what exactly are you doing for
16 Blue Cross Blue Shield of North Carolina? You said program
17 analytics. What does that mean?

18 A. As I previously stated, it's actually working with
19 a lot of various customers within the organization just on
20 reports, building reports, and delivering them to our
21 internal customers.

22 Q. When you say "internal customers," do you mean
23 folks that work for Blue Cross Blue Shield of North
24 Carolina?

25 A. Correct.

EXHIBIT G

Jay Ludlam, J.D.

4601 Whitnire Pl
Raleigh, NC 27612

P 573-823-1708
E Jay.Ludlam@gmail.com

High-performing, recognized leader with proven accountability for managing a Medicaid state agency and leading others in identifying and resolving complex technical, operational and organizational problems.

EXPERIENCE

Department of Health & Human Services, Division of Health Benefits, RALEIGH, NC

ASSISTANT SECRETARY FOR MEDICAID TRANSFORMATION

AUGUST 2017 – PRESENT

Licensed to practice
law in Missouri

Executive lead for implementing state-wide Medicaid Managed Care program affecting over 1.6 million lives, including pregnant women & children transitioning from fee-for-service to managed care

MO HealthNet Division, JEFFERSON CITY, MO

ACTING MEDICAID DIRECTOR

JANUARY 2017 – AUGUST 2017

DEPUTY DIVISION DIRECTOR

AUGUST 2014 – DECEMBER 2016

Appointed lead of Missouri's Medicaid agency units with responsibility for budget and fiscal operations, information services, provider and participant support, human resources, and Medicaid program administration, in addition to providing health benefits to approximately 975,000 lives.

Recognized Leader

Executive Leadership
Program
(Missouri State
Government – 2017)

Essentials of Managed
Care Program
(WellCare – 2014)

Developing Leader
Program
(Aetna – 2013)

Medicaid Business Unit
Leadership Program
(Aetna – 2012)

Executive lead for implementing state-wide Medicaid Managed Care program expansion affecting over 750,000 lives, including pregnant women & children transitioning from fee-for-service to managed care:

- Implemented quality and care management innovations encouraging Medicaid delivery reform and market transformation such as health homes, certified community behavioral health centers (CCBHCs), and accountable care organizations (ACOs);
- Led division Medicaid Care Management reforms, including Care Management Organization accountability, provider responsibility for quality outcome and containing costs, participant incentives for healthy behaviors, integrating behavioral health care with physical health care, and empowering provider change;
- Developed innovative contract oversight program utilizing a process-risk approach, coupled with an expanded capitation-withhold program to control managed care organization operational and quality risks while maintaining actuarial rate soundness.

Closed \$27 million MO State Auditor finding through business process review (BPR) focused changes, increasing existing staff efficiency and potential third-party liability recovery at no additional cost to the Medicaid program.

Licensed to practice
law in Missouri

- Accountable for information service maintenance & operations, development, state-procurement, and contracting for MMIS, Business Information System-Enterprise Data Warehouse (BIS-EDW) and related-systems that verify eligibility, process claims, and reimburse providers for 100 million annual health care claims, authorizations, encounters, and point-of-service (POS) transactions annually.



MISSOURI ATTORNEY GENERAL'S OFFICE, JEFFERSON CITY, MO
ASSISTANT ATTORNEY GENERAL

MAY 2007 – AUGUST 2009

- Prosecuted white-collar criminal and civil fraud for Medicaid Fraud Control Unit.
- Negotiated criminal plea agreements and civil settlements, recovering \$1.3 million.
- Prepared criminal complaints, investigative subpoenas and search warrants; engaged in complex civil discovery and motion practice.
- Coordinated local prosecutors, investigators, auditors and computer analysts to develop cases for prosecution.
- Awarded \$1.8 million on summary judgment as part of civil prosecution case; affirmed by the Missouri Supreme Court (State v. Spilton, 315 S.W.3d 350 (Mo. banc 2010)).

MURPHY & TOBIN LAW FIRM, KANSAS CITY, MO
LAW CLERK

MARCH 2006 – MAY 2007

- Assisted with computer system lease enforcement and contract cases.

NEXTCARD, INC., SAN FRANCISCO, CA
DIRECTOR OF CUSTOMER LOYALTY PLATFORMS

OCTOBER 1998 – NOVEMBER 2002

- Awarded patent for developing real-time data interface and corresponding business logic to identify and obtain outstanding bank balance information. (On-line balance transfers, US 8010422).
- Identified the need for and developed a "one-click" email sales platform which improved net conversions and resulted in a 500% increase in email response rates.
- Successfully migrated 400,000 Rewards customers and points balances to a new vendor with minimal disruption to customer service or customer experience.
- Developed customer privacy policy - first credit card company to earn an eTrust Trustmark.
- Administered sites ranked #1 for online credit cards 4 out of 5 quarters (Gomez 2000-2001).
- Oversaw platforms that accounted for 25% of new assets from existing customers in 2001.

FAMILY EDUCATION COMPANY, BOSTON, MA
MARKETING ANALYST

JANUARY 1998 – JUNE 1998

- Enhanced online traffic measurement methods to improve reporting accuracy, visitor path analysis, and promotional tracking. Implemented "splash pages" to track campaign response, consumer demographics and site behavior.
- Devised and implemented online market research surveys to capture customer demographics and obtain customer feedback. Analyzed visitor usage reports and generated key learning to guide future visitor acquisition and retention efforts.

EDUCATION

Juris Doctorate – UNIVERSITY OF MISSOURI - KANSAS CITY

Bachelor of Arts, Social Psychology – GRINNELL COLLEGE

- Educational background [enclosed resume]
- Work experience [enclosed resume]
- Title and role with the Department;
 - Assistant Secretary for Medicaid
- Any specific experience with:
 - Medicaid; [enclosed resume +]

Medicaid Fraud Control Unit within the Missouri Attorney General's Office (2007-2009)

Prosecuted white-collar criminal and civil fraud for Medicaid Fraud Control Unit.

Negotiated criminal plea agreements and civil settlements recovering \$1.3 million.

Prepared criminal complaints, investigative subpoenas and search warrants; engaged in complex civil discovery and motion practice.

Coordinated local prosecutors, investigators, auditors and computer analysts to develop cases for prosecution.

Awarded \$1.8 million on summary judgment as part of civil prosecution case (aff'd, State v. Spilton, 315 S.W.3d 350 (Mo. banc 2010)).

Aetna/Missouri Care

Medicaid Compliance

Responsible for auditing, investigating, training/education and enforcement of federal and state laws and regulations for multiple Medicaid programs including Missouri, Indiana, New Hampshire and Maine.

Accountable for monitoring, reporting, adherence and implementing compliance controls, including related-company standards.

Oversees preparation and filing of regulatory reports and responses to regulator inquiries; negotiates resolution of issues identified.

Coordinates and oversees compliance audits and internal and external examinations; models ethical behavior in all situations.

Lead policy review of the Missouri health plan and managed administrative compliance to meet NCQA accreditation requirements

Aetna Claims Operations and Provider Setup Manager

Jun 2010 – Jun 2012

Identified need for systemic change and executed strategy to improve efficiencies with contract, benefit, and fee schedule configuration; 97% of projects completed within 60 days and \$450,000 annual cost savings.

Responsible for contract/benefit configuration and claims processing, appeals, reversals, and refunds.

Implemented S-OX contract validation controls on 250+ contract configurations.

Coordinates the technical implementation of physician / facility contract and roster loads including benefit, fee schedules and regulatory changes.

Develops and leads process and quality improvement initiatives.

Manages the coordination of benefits verification and third party liability coordination functions for the health plan.

Director of Operations (Sr. Manager of Claims)

Company NameMissouri Care, a WellCare Health Plan

Dates EmployedJun 2012 – Sep 2014

Employment Duration2 yrs 4 mos

LocationColumbia, MO

Led operational and clinical integration with a pediatric Medicaid accountable care organization, delegating health plan administration to encourage better population-based clinical management, medical home support and payment system reform to benefit providers and participants.

Leader of operational units at an NCQA accredited, managed care organization with multiple Medicaid / Medicare lines of business in Missouri and S. Illinois.

Responsible for all functions and staff in Provider Relations, Provider Operations and Configuration, Claims oversight, Call Center and Credentialing departments.

Guided departments through major milestones including NCQA Accreditation, expansion from 49k to 108k members, and a corporate acquisition, with focus on risk mitigation, value creation, compliance, and client and member satisfaction.

WellCare acquired Missouri Care from Aetna in April 2013.

- o Managed care; [enclosed resume]

Compliance or Operations experience in managed care for markets in Missouri, Maine, New Hampshire, Indiana (pharmacy prior authorization) contract, Southern Illinois and North Carolina

Local health plan compliance or operations experience – Missouri and Southern Illinois

Remote compliance – IN, ME, NH

State Medicaid Agency experience – MO, NC

Different program health plan experience included shutting down an ASO (MO), Medicaid Managed Care (MO, NC), PACE (MO)

- o Complex government programs;

NextCard – Regulation Z compliance (“Schumer box” disclosures); privacy

Missouri Care - Sarbanes-Oxley compliance (S-OX)

Attorney General’s Office

Medicaid – MMIS, ICD-10 conversion, State Auditor, Managed Care, PACE, implementation of largest/first in nation CCBHC demonstration, NC Transformation

- o Procurement;

At State Agencies (MO and NC) indirectly managed teams which drafted, initiated, procured, implemented or managed ongoing multiple contracts – eg: Third Party Liability renewal, BIS-EDW, MMIS, enrollment broker, EQRO, member ombudsman

Executed sole source contracts and negotiations for business services, IT and administrative

- o Contracts with vendors for managed care; [Enclosed resume] and
- o Any prior experience with a transformation to a Medicaid managed care system.

Conversion of Aetna health plan to a WellCare healthplan as part of the Aetna-Coventry merger settlement - in approximately 45-60 days.

Extended Missouri Medicaid into rural counties which had not had Medicaid Managed Care (May 2017)

North Carolina Transformation

EXHIBIT H

IN THE OFFICE OF ADMINISTRATIVE HEARINGS

Optima Family Care of North Carolina,
Inc.,

Petitioner,

COUNTY of WAKE

19 DHR 01959

v.

North Carolina Department of Health
and Human Services, Mandy Cohen M.D.,
MPH in her official capacity as
Secretary of the Department and Dave
Richard in his official capacity as
Deputy Secretary of the Department of
NC Medicaid,

Respondents,

and

WellCare of North Carolina, Inc.,
Blue Cross and Blue Shield of North
Carolina, AmeriHealth Caritas of
North Carolina, Inc., Carolina
Complete Health, Inc.,

Respondent-Intervenors.

(Captions continued on page 2)

VOLUME I

DEPOSITION OF PATRICK DOYLE

September 9, 2019

Reporter: Elaine F. Hayes, Court Reporter
WORDSERVICES, INC.
1102 Driftwood Drive
Siler City, North Carolina 27344
919.548.4914
wanda@mywordservices.com

North Carolina Provider Owned Plans,
Inc., d/b/a My Health by Health
Providers,
Petitioner,

COUNTY of WAKE
19 DHR 02032

v.

North Carolina Department of Health
and Human Services,
Respondent,

and

UnitedHealthcare of North Carolina,
Inc., Blue Cross and Blue Shield of
North Carolina, WellCare of North
Carolina, Inc., AmeriHealth Caritas
of North Carolina, Inc., Carolina
Complete Health, Inc.,
Respondent-Intervenors.

Aetna Better Health of North
Carolina, Inc. d/b/a Aetna Better
Health of North Carolina,
Petitioner,
v.

COUNTY of WAKE
19 DHR 02194

State of North Carolina Department of
Health and Human Services,
Respondent,
and

WellCare of North Carolina, Inc.,
Blue Cross and Blue Shield of North
Carolina, AmeriHealth Caritas of
North Carolina, Inc.,
UnitedHealthcare of North Carolina,
Inc., Carolina Complete Health, Inc.,
Respondent-Intervenors.

(Captions continued on page 3)

Carolina Complete Health, Inc., COUNTY of WAKE
Petitioner, 19 DHR 03352

v.

North Carolina Department of Health
and Human Services,
Respondent.

DEPOSITION OF PATRICK DOYLE

VOLUME I

PAGES 1 - 281

September 9, 2019

9:00 a.m.

Law Offices of

Parker Poe Adams & Bernstein

301 Fayetteville Street, Suite 1400

Raleigh, North Carolina 27601

1 would have been providing information to a procurement team?

2 A. Correct.

3 Q. All right. And then you were the interim
4 director/IT director at Centene?

5 A. Centene, correct. And it was actually -- they
6 were Cenpatico, but they were a division of Centene.

7 Q. Gotcha. You're talking about TriWest?

8 A. No.

9 Q. Oh, you're talking about at Centene, it was a
10 division of --

11 A. At Centene -- or Cenpatico was a subdivision, for
12 want of a better word, of Centene.

13 Q. Gotcha. So the actual name of the company that
14 you worked with would have been Cenpatico?

15 A. Cenpatico, correct.

16 Q. I understand. And at Cenpatico, you were an
17 interim IT director?

18 A. Correct.

19 Q. And Centene has some ownership interest in
20 Cenpatico. Is that correct?

21 A. Yes, correct.

22 Q. And was that also in the same state? Were you
23 in --

24 A. It was in Arizona, yes.

25 Q. Right. And how long did you serve in that role?

EXHIBIT I

PROFESSIONAL EXPERIENCE

Aetna, Inc. – Raleigh, NC

Sept 2016 - Present

Director of Business Development, Aetna Medicaid

- Led the development of Aetna's Medicaid plan and response to the North Carolina Medicaid managed care transformation RFP.
- Developed and implemented the social determinant of health investment strategies into local community benefit organizations (CBOs).
- Coordinated and led cross-functional teams whose participation includes: plan design, network development, actuarial, clinical, regulatory, health services and government affairs.
- Serves as single point of contact for North Carolina Medicaid market leadership and supports market leads in other states.
- Maintains up to date market intelligence to understand market needs, competitive activity and emerging opportunities.

North Carolina Division of Health Benefits – Raleigh, NC

Jan 2016 – Aug 2016

Senior Program Manager, Business Operations

- Helped lead and develop Medicaid 1115 waiver and policy reports needed to transform Medicaid from a fee-for-service reimbursement model to capitation.
- Worked in coordination with Division of Medical Assistance (DMA) to develop future Medicaid procedures, policies, and processes needed under capitation.
- Led stakeholder engagement efforts to inform, educate, and update stakeholders on transition, policy development, and work stream progress.

North Carolina Department of Health and Human Services – Raleigh, NC

July 2014 – Dec 2015

Senior Healthcare Analyst, Budget and Analysis

- Led development of strategic plan and policies needed to transform Medicaid from a fee-for-service reimbursement model to capitation.
- Utilized research methods to analyze contracts and various data sets, develop legislative reports, and provide analysis support.
- Gathered data and conducts ad-hoc analyses as directed by Secretary, CFO, or other members of the leadership team.
- Restructured PACE (Program for All-inclusive Care for the Elderly) budget and developed strategic growth plan.

AJJ000005

North Carolina Hospital Association (NCHA) – Raleigh, NC
Director of Government Relations

Jan 2007 – Dec 2012

- Led NCHA advocacy efforts in Washington, DC and in Raleigh, NC. Identified and developed strategies to address key health system advocacy issues.
- Supervised the NCHA government relations team, 25-member health system in-house government relations officers to meet objectives for all legislative and regulatory activities.
- Collaborated with health system executives and physicians to identify and address operations concerns. Trained health system executives and physicians to optimize the use of operations and financial data to effectively communicate an advocacy message.
- Educated elected officials, public opinion leaders, and government agencies on health system operations and the impact of legislative changes on patient care, quality and process improvement, Medicaid and Medicare, and reimbursement.
- Served as Hospital Association Political Action Committee (HOSPAC) Treasurer. Responsible for fundraising, management of incoming and outgoing funds, oversight of HOSPAC Board activities, and filing state and federal reports. Raised \$200,000+ annually.

Deloitte Consulting – Atlanta, GA
Senior Consultant, Healthcare and Life Sciences Practice

Sept 2005 – Dec 2006

- Evaluated potential options to respond to negative margins for a 1,550-bed academic medical center-owned health plan. Assisted in the development of a new operating plan for both the health plan and hospital system.
- Assisted in designing and developing efficient and cost-effective processes for annual budget planning, strategic enterprise planning, and capital management planning for a health insurance plan with more than 3 million members.
- Led a strategic quality improvement project and managed accreditation survey preparation for a 700-bed Midwestern academic medical center.
- Created and executed strategy to identify unique customer segments and improve the alignment of product offering and price with customer need for a Fortune 500 medical device manufacturer.

Hospital Corporation of America (HCA) – Tampa, FL
Associate Administrator/Ethics and Compliance Officer (ECO)

June 2003 – Aug 2005

- Managed 5 departments of Brandon Regional Hospital, a 327-bed, investor-owned regional hospital with an annual operating budget of \$900 million in gross revenues, including: Cardiac Services, Food and Nutrition Services, Laboratory Services, Ethics/Compliance, and Pharmacy; with annual gross revenues of \$180 million and 123 FTE's.

The Duke Endowment – Charlotte, NC
Assistant Director, Health Care Division

1996 – 2000

- \$2.5 billion non-profit organization that annually awards \$100 million in grants, including \$36 million in healthcare grants to 168 hospitals in North Carolina and South Carolina.
- Managed, distributed, and administered \$12 million in annual healthcare grants.
- Created database to track and analyze hospital financial information and grant-making trends.
- Conducted an annual comparative statistical and financial analysis of all beneficiary hospitals.
- Developed and presented investment recommendations and financial structure of hospital grants to the Endowment Trustees. Consulted with hospital administrators to analyze investment feasibility and monitored progress on existing grants.
- Designed and launched a \$6 million wellness initiative. Managed grant programs in construction and capital improvements of hospitals, disease case management, and improving treatment of the elderly.

Charlotte Country Day School – Charlotte, NC
Middle School Science Teacher

1995-1996

- Designed and taught science curriculum.

RELATED EXPERIENCE AND AFFILIATIONS

- LEAN Green belt Six Sigma certified.
- Campaign Chair, United Way, at The Duke Endowment, Brandon Hospital, and NCHA (1996 – 2012). Achieved significant increases in fundraising each year at NCHA.

EDUCATION

- Master of Healthcare Administration (2003), Gillings School of Global Public Health, University of North Carolina at Chapel Hill, Chapel Hill, NC
- Master of Business Administration (2002), Kenan-Flagler Business School, University of North Carolina at Chapel Hill, Chapel Hill, NC
- Bachelor of Science - Biology (1995), Davidson College, Davidson, NC

STATE OF NORTH CAROLINA

IN THE OFFICE OF
ADMINISTRATIVE HEARINGS

COUNTY OF WAKE

OPTIMA FAMILY CARE OF NORTH
CAROLINA, INC.,

Petitioner,

v.

NORTH CAROLINA DEPARTMENT
OF HEALTH AND HUMAN
SERVICES, MANDY COHEN M.D.,
MPH, in her official capacity as
Secretary of the Department, and
DAVE RICHARD, in his official
capacity as Deputy Secretary of the
Department of N.C. Medicaid,

Respondents,

and

WELLCARE OF NORTH CAROLINA,
INC.; BLUE CROSS AND BLUE
SHIELD OF NORTH CAROLINA;
AMERIHEALTH CARITAS OF
NORTH CAROLINA, INC.;
CAROLINA COMPLETE HEALTH,
INC.,

Respondent-Intervenors.

19 DHR-01959

NORTH CAROLINA PROVIDER
OWNED PLANS, INC., d/b/a MY
HEALTH BY HEALTH PROVIDERS,

Petitioner,

v.

19-DHR-02032

<p>NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES,</p> <p>Respondent,</p> <p>and</p> <p>UNITEDHEALTHCARE OF NORTH CAROLINA, INC.; BLUE CROSS AND BLUE SHIELD OF NORTH CAROLINA; WELLCARE OF NORTH CAROLINA, INC.; AMERIHEALTH CARITAS OF NORTH CAROLINA, INC.; CAROLINA COMPLETE HEALTH, INC.,</p> <p>Respondent-Intervenors.</p>	
<p>AETNA BETTER HEALTH OF NORTH CAROLINA, INC. d/b/a AETNA BETTER HEALTH OF NORTH CAROLINA,</p> <p>Petitioner,</p> <p>v.</p> <p>STATE OF NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES,</p> <p>Respondent,</p> <p>and</p> <p>WELLCARE OF NORTH CAROLINA, INC.; BLUE CROSS AND BLUE SHIELD OF NORTH CAROLINA' AMERIHEALTH CARITAS OF NORTH CAROLINA, INC.; CAROLINA COMPLETE HEALTH, INC.,</p>	<p>19-DHR-02194</p>

Respondent-Intervenors.	
CAROLINA COMPLETE HEALTH, INC., Petitioner, v. NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES, Respondent.	19-DHR-03352

**WELLCARE OF NORTH CAROLINA, INC.’S RESPONSE OPPOSING
AETNA BETTER HEALTH OF NORTH CAROLINA INC.’S MOTION FOR
LEAVE TO AMEND ITS PETITION FOR A CONTESTED CASE HEARING**

WellCare of North Carolina, Inc. (“WellCare”) responds in opposition to Aetna Better Health of North Carolina Inc.’s Motion and Memorandum for Leave to Amend its Petition for a Contested Case Hearing (“Motion”).

I. INTRODUCTION

Aetna Better Health of North Carolina, Inc. (“Aetna”) seeks leave to amend its April 16, 2019 Petition for a Contested Case Hearing (“Petition”) based on Aetna’s alleged “recent discovery of new facts” relating to the Evaluation Committee scoring a reference submitted by Blue Cross and Blue Shield of North Carolina (“BCBS”) during a quality assurance process. (Motion p. 3.) The facts described in Aetna’s Motion, however, are not new facts. Instead, the same records Aetna had and reviewed before filing its bid protest with the Department of Health and Human

Services (the “Department”) on March 5, 2019 also disclose the facts that Aetna now seeks to use to launch new claims.

Pursuant to Rule 15 of the North Carolina Rules of Civil Procedure “a party may amend his pleading only by leave of court or by written consent of the adverse party;¹ and leave shall be freely given when justice so requires.” N.C. Gen. Stat. § 1-A-1, Rule 15(a). Motions for leave to amend should be denied when opponents can show undue delay, bad faith, undue prejudice, or futility of amendment. *See Rabon v. Hopkins*, 208 N.C. App. 351, 353, 703 S.E.2d 181, 184 (2010); *see also Draughton v. Harnett Cty. Bd. of Educ.*, 166 N.C. App. 464, 467, 602 S.E.2d 721, 724 (2004). Aetna’s Motion should be denied based on undue delay as well as futility of amendment.

II. ARGUMENT AND AUTHORITIES

A. Aetna’s Proposed Amendment is Untimely

Aetna’s Motion seeks to add new claims that are untimely and about which Aetna has been aware—or should have been aware—since before filing its protest with the Department in March 2019. Specifically, Aetna claims that it “recently learned *for the first time*” that on January 18, 2019, the initial tabulated scores were disclosed to the Evaluation Committee showing Aetna in the top four offerors, and only after scoring of a BCBS reference following a quality assurance review did Aetna drop out of the four highest scoring offerors. (Motion p. 4 (emphasis in original).)

¹ Aetna’s Motion indicates that the Department does not consent to Aetna’s requested amendment. (Motion p. 5.)

Aetna's failure to comprehend information presented to it months ago, however, does not amount to "new facts."

In February 2019 the Department responded to Aetna's public records request by providing Aetna with, among other things, a document entitled Attachment #4 PHP Evaluation Committee Meeting Notes and Timeline (the "Timeline").² The Timeline is a 94-page record of the Evaluation Committee's proceedings with entries for each day that the Evaluation Committee met. The Timeline shows that:

- On December 18, 2018, the Evaluation Committee asked to consult with Department legal counsel concerning "BCBS's use of BlueChoice Health Plan of South Carolina as a reference" and pending consultation that reference was not scored.
- On December 19, 2018 the Evaluation Committee "scored a reference for Aetna (Mercy Care)."
- Also on December 19, 2018, the Evaluation Committee decided by consensus not to score the BCBS reference because of questions regarding whether it was submitted by an independent entity or an affiliated entity.
- On January 18, 2019, having completed scoring of all questions, the Evaluation Committee reviewed the score results for the first time "with the understanding that quality assurance activities were ongoing and scores would not be final until that process was complete." The next step of the quality assurance process would be for the Department's legal counsel to "review the scoring of Offeror Client References."
- On January 22, 2019, the Evaluation Committee discussed the findings of Department legal counsel's review of Offeror Client References including that the BCBS reference which was not scored appeared similar to the Aetna reference from Mercy Care that was scored. The Evaluation Committee then determined that the BCBS reference should be scored "and the scoring was updated accordingly." A summary of the updated scores was reviewed and discussed and the Evaluation

² The Timeline later was filed by Department on May 3, 2019 in Aetna's contested case as Exhibit F to Mona Moon's Affidavit included as an attachment to Respondent's Memorandum of Law in Opposition to Petitioner's Motion for Preliminary Injunction.

Committee determined its award recommendation based on the updated scores.

Timeline pp. 13-14, 20-22. Relevant pages of the Timeline are attached to this response as ***Exhibit A***.

From the Timeline, which it received in February, Aetna knew or should have known that: (1) the BCBS reference initially was not scored; (2) on January 18, 2019, the Evaluation Committee reviewed the initial overall scores including BCBS's score without the reference; (3) on January 22, 2019, the Evaluation Committee decided to score the BCBS reference following review as part of the quality assurance process and the scores were updated accordingly; and (4) the Evaluation Committee's contract award recommendations were based on the updated scores. Additionally, as Jamal Jones of Aetna testified in his deposition on September 30, 2019, the public records the Department produced to Aetna in February 2019 included detailed scoring documents. These records showed that each reference was worth up to 12.5 points.

Indeed, when it lodged its bid protest on March 5, 2019, Aetna protested its fifth-place finish, which it calculated was the result of a 2.0606 point deficit compared with fourth-place finisher AmeriHealth Caritas North Carolina ("ACNC"), and a difference between Aetna and BCBS of 7.62287 points. (Petition, Exhibit A, p. 3.) Related to that deficit, Aetna's protest describes in detail why Aetna believes it should have received more points, and ACNC should have received fewer points, for certain questions. Aetna's protest, however, does not assign any error to, and does not mention at all, the scoring of any of BCBS's references.

To the extent that Aetna has only recently discovered the facts relating to the scoring of the BCBS reference, this is due to Aetna's lack of diligence in reviewing the public records provided to it by the Department prior to Aetna filing its bid protest. It is not because such information recently became available to Aetna. Had Aetna simply subtracted 12.5 points from BCBS's final score to reflect the initial scores as reviewed by the Evaluation Committee on January 18, 2019,³ Aetna would have known prior to filing its protest that Aetna was in the top four scoring offerors before the scores were updated to include the BCBS reference on January 22, 2019. Thus, to the extent the scoring of BCBS's reference is of concern to Aetna, this issue should have been raised in Aetna's protest.

Aetna also failed to raise any claim regarding the scoring of BCBS's reference in its Petition. Pursuant to N.C. Gen. Stat. § 150B-23, Aetna was required to file a petition contesting the Department's contract awards within 60 days of the Department's denial of Aetna's protest and any such petition was required to state the facts that Aetna contends entitles it to relief. N.C. Gen. Stat. § 150B-23(a), (f). Aetna is attempting to raise such claim now through an amendment more than six months after Aetna filed its protest and more than five months after Aetna filed its Petition. Aetna's proposed amendment is untimely and Aetna has no excuse for its

³ Aetna complains that it only recently received a scoring spreadsheet from January 18, 2019, which displayed the initial ranking of each of the offerors when the Committee conducted its initial review of scores prior to the quality assurance process. The Department has indicated that it did not provide this record sooner because it is a spreadsheet that includes confidential proprietary information of the other offerors as part of the entire document. Aetna, however, could have, and should have, computed its initial and updated scores and those of BCBS based on the information the Department provided to Aetna in February 2019. It did not need the January 18, 2019 version of the spreadsheet to do so.

undue delay except that Aetna failed to put the pieces of the puzzle together based on facts that were in plain sight.

“In deciding if there was undue delay, the trial court may consider the relative timing of the proposed amendment in relation to the progress of the lawsuit.” *Draughton*, 166 N.C. App. at 467, 602 S.E.2d at 724. Courts have denied motions for leave to amend based upon undue delay when “a party seeks to amend its pleading after a significant period of time has passed since filing the pleading and where the record or party offers no explanation for the delay.” *Rabon*, 208 N.C. App. at 354, 703 S.E.2d at 184; *see also Walker v. Walker*, 143 N.C. App. 414, 418, 546 S.E.2d 625, 628 (2001) (citing cases where significant time passed since the operative pleading the movants desired to amend); *Walker v. Sloan*, 137 N.C. App. 387, 402-03, 529 S.E.2d 236, 247 (2000) (affirming trial court’s order denying motion for leave where plaintiff sought to amend complaint three months after an answer was filed with no explanation in the record for the delay); *Caldwell’s Well Drilling, Inc. v. Moore*, 79 N.C. App. 730, 731, 340 S.E.2d 518, 519 (1986) (affirming trial court’s denial of leave to amend where plaintiff waited three months before moving to amend its complaint based upon information in the defendant’s answer).⁴

Aetna should not be allowed to raise new claims for the first time as discovery comes to a close which Aetna failed to raise in its protest and Petition despite having

⁴ The case Aetna cites in its Motion is not as broad as the proposition for which Aetna says it stands. The court in *Global Textile Alliance, Inc. v. TDI Worldwide, LLC*, No. 17 CVS 7304, 2018 WL 1720822 (N.C. Ct. Super. Apr. 6, 2018) did not grant the plaintiff’s motion for leave to amend in its entirety. 2018 WL 1720822, at *5. Rather, the court granted the motion for leave to amend to add new factual allegations where they “expand[ed] on or provide[d] some additional detail regarding claims *already contained* in the Amended Complaint.” *Id.* (noting that “many of the new facts . . . could not have been known” when the original complaint was filed) (emphasis added).

all relevant facts in its possession for more than six months. Aetna's Motion should be denied because of Aetna's undue delay.

B. Aetna's Proposed Amendment Is Futile

Aetna's Motion seeking to add these untimely claims also should be denied as futile. *See, e.g., Global Textile Alliance*, 2018 WL 1720822, at *6 (denying motion for leave to amend to add claims that were futile because they did not contain any facts supporting the claim and were instead merely unsupported legal conclusions); *see also Carter v. Rockingham Cty. Bd. of Educ.*, 158 N.C. App. 687, 690-91, 582 S.E.2d 69, 72-73 (2003) (affirming the trial court's denial of a motion for leave, in part, based on futility, because plaintiff had refuted the allegations he sought to add to the complaint through a sworn deposition in the case).

The Timeline plainly shows that the quality assurance review revealed that the BCBS reference which was not initially scored was similar to Aetna's reference from Mercy Care, which was scored. As both references were similar, the Department could not treat the similar references differently. For the Department to do so would have been arbitrary and capricious and would have given Aetna an unfair competitive advantage.

Thus, the options available to the Evaluation Committee included scoring the BCBS reference, or not scoring Aetna's reference. Amending its claims to provide that BCBS's reference should not have been scored would mean that Aetna's reference for Mercy Care also should not have been scored, still leaving Aetna in fifth place.

Under N.C. Gen. Stat. § 150B-23, Aetna must show that the Department has substantially prejudiced Aetna's rights. N.C. Gen. Stat. § 150B-23(a); *see also AH N.C. Owner LLC v. N.C. Dep't of Health & Human Servs.*, 240 N.C. App. 92, 98, 771 S.E. 2d 537, 541 (2015) (quoting *CaroMont Health, Inc. v. N.C. Dep't of Health & Human Servs.*, 231 N.C. App. 1, 4, 751 S.E.2d 244, 248 (2013)). Due to the fact that the similar references had to be treated in a similar manner, Aetna still would have fallen behind BCBS in points regardless of whether the BCBS and Aetna references were both scored or not scored. Thus, Aetna cannot show that it was prejudiced by the scoring of the BCBS reference. Because it cannot succeed on the new untimely claims it seeks to assert through amendment, Aetna's Motion also should be denied based on futility.

III. CONCLUSION

For all the foregoing reasons, WellCare respectfully requests that the Tribunal deny Aetna's Motion and require Aetna to proceed on the allegations in its Petition filed on April 16, 2019.

Respectfully submitted this 4th day of October, 2019.

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CERTIFICATE OF SERVICE

I hereby certify that on this date, I served the foregoing **Motion to Intervene** by electronic service through electronic filing with the Office of Administrative Hearings, as defined in 26 N.C.A.C. 03 .0501(4), and by electronic mail on those listed below:

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This the 4th day of October, 2019.

/s/ Shannon R. Joseph
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EXHIBIT A

Attachment #4 PHP Evaluation Committee Meeting Notes and Timeline

October 17, 2018, 10:00 AM – 12:00 PM

Kick Off Meeting for Evaluation Committee.

Attendees and Roles:

Scoring Members:	Non-Scoring Contract Leads	Non-Scoring Subject Matter Expert (SME)	Non-Scoring Legal Counsel	Non-Scoring Leadership
Tabitha Bryant Melanie Bush Patrick Doyle Sabrena Lea Catherine Pace Sheila Platts Amanda Van Vleet	Kimberly Kilpatrick Gregory Sligh	Sarah Gregosky	Lotta Crabtree	Jay Ludlam Mona Moon

1. See *Attachment #3 PHP Evaluation Kick-Off Meeting – Scoring Members* for the meeting presentation.
2. The Contract Leads conducted the Kick-Off Meeting. Items discussed included:
 - a. Ensuring and maintaining the integrity of the procurement process.
 - b. Confidentiality and Conflict of Interest Statements (Statements).
 - c. Location and process to access evaluation materials on SharePoint upon completion of the Statements.
 - d. Hardcopies of proposals also available in evaluation meeting room but must not leave the McBryde building
 - e. Evaluation ground rules.
 - f. Time commitment.
 - g. Notetaking. The attendees were advised that notes, if any, will be taken up during the evaluation and become part of the solicitation file.
 - h. Consensus scoring will be used. The Scoring Members will review and discuss the responses, determine if they need guidance from a SME or a Clarification to any Offeror's response, and work to reach consensus on the final score for each evaluation question.
 - i. Blocks of time will be scheduled, and specific sections to be discussed and scored will be communicated in advance of each meeting.
 - j. SMEs to be notified and scheduled in advance of scoring specific sections to provide any information requested prior to scoring a section.
 - k. Discussed the 5 Level Rating Scale Definitions. The baseline for scoring, where applicable, is that each response Meets Expectations. If the Committee

December 17, 2018

Evaluation Committee Meeting

Attendees: Cathy Pace, Patrick Doyle, Sheila Platts, Sabrena Lea, Amanda Van Vleet, Melanie Bush, Tabitha Bryant, SME Deirdre Brown (attended briefly), SME Alfred Greco (attended briefly), SME Jean Holliday (attended briefly), SME Julia Lerche (attended briefly), Kimberley Kilpatrick and Gregory Sligh.

1. Posed the Confidentiality and Conflict of Interest question to the Committee – no conflicts.
2. Deirdre Brown, Alfred Greco, Jean Holliday and Julia Lerche provided an overview of the responses and answered the Committee's questions on the Financial Requirements section for questions 57 – 59.
3. The Committee began and completed scoring questions 57-59 of the Financial Requirements section for Aetna, AmeriHealth, BCBS, CCH, My Health, Optima, United and WellCare.
4. The Committee decided to not score question 59.a. for BCBS until a clarification was obtained and Committee could consult with SME Jean Holliday.

December 18, 2018

Evaluation Committee Meeting

Attendees: Cathy Pace, Patrick Doyle, Sheila Platts, Melanie Bush, Sabrena Lea, Tabitha Bryant, Amanda Van Vleet, SME John Thompson (attended briefly), SME Sarah Gregosky (attended briefly), Kimberley Kilpatrick and Gregory Sligh.

1. Posed the Confidentiality and Conflict of Interest question to the Committee – no conflicts.
2. John Thompson provided an overview of the responses and answered the Committee's questions on the Compliance section for questions 60 – 63.
3. The Committee began scoring Offeror's Client References for Aetna (Florida, Virginia DMAS) AmeriHealth (Delaware, Michigan), BCBS (Maryland, South Carolina), CCH (New Hampshire, Kansas, Superior HealthPlan, Inc. of Texas), My Health (Centennial Care, University of New Mexico Hospital Medical Group, Presbyterian Medical Services), Optima (Huntsville Hospital Health System, Virginia Division of Medical Services – Operations, Virginia Division of Medical Services – Integrated Care), United (Michigan Department of Health and Human Services, Rhode Island Department of Health and Human Services, Kansas KDHE) and WellCare (Staywell Health Plan of Florida).
4. The Committee asked to consult with Lotta Crabtree concerning BCBS's use of BlueChoice Health Plan of South Carolina as a reference and Optima's use of Huntsville Hospital Health System. Pending on the consultation the references were not scored.
5. Sarah Gregosky gave an overview of Use Case Scenarios.

Contracting Team Note: Kimberley Kilpatrick called Lotta Crabtree and posed the questions from the Committee on the two references in Item #4 above. Advised the Committee to be consistent in determining if the reference was a client reference and relevant to the scope of services.

December 19, 2018

Evaluation Committee Meeting

Attendees: Cathy Pace, Melanie Bush, Sheila Platts, Tabitha Bryant Patrick Doyle, Sabrena Lea, SME Jean Holliday (attended briefly), Amanda Van Vleet, Kimberley Kilpatrick and Gregory Sligh.

1. Posed the Confidentiality and Conflict of Interest question to the Committee – no conflicts.
2. Jean Holliday explained question 11, commitment to offer QHPs, scoring. Reviewed the information obtained as part of CCH Clarification #1 and United Clarification #1. Committee scored question 11 based on the information provided by Jean Holliday. See *Attachment #9 Question 11 Data* and *Attachment #10 Question 11 NC County Exchange Enrollment* for information on how the points were calculated and responses scored
3. The Committee scored a reference for Aetna (Mercy Care).
4. Legal Counsel Lotta Crabtree advised the Committee to be consistent in their consideration, treatment and scoring of references. Based on the consultation for the BCBS and Optima references on December 18 for Item #4, the consensus was to not score the references as the BCBS reference was deemed not a “client reference” and services were never implemented for the Optima reference.

SME Activity Note: Prior to meeting with the Committee to review question 11, quality assurance and verification of the data and formulas were conducted by SMEs Jean Holliday and Sarah Gregosky.

December 20, 2018

Contract Team Note: BCBS Clarification #2 to confirm Financial Management question 56 issued 12/20/2018 and returned 12/20/2018. SME Jean Holliday reviewed and confirmed it provided the necessary information. Jean will share with Committee upon return in January 2019. See *Table 2 – Offeror Clarifications* for additional information.

January 2, 2019

Evaluation Committee Meeting

Attendees: Sheila Platts, Cathy Pace, Patrick Doyle, Amanda Van Vleet, Melanie Bush, Sabrena Lea, SME Reginald Little (attended briefly), SME Lynne Testa (attended briefly), SME Julia Lerche (attended briefly), SME Jean Holliday (attended briefly), Kimberley Kilpatrick and Gregory Sligh.

1. Posed the Confidentiality and Conflict of Interest question to the Committee – no conflicts.

5. The Committee agreed to reconvene January 18 at 10:30 AM to review the United Clarification #2.
6. The Committee reviewed the scores to confirm the documentation for scores of Exceeds/Substantially Exceeds were clear and detailed where possible. See *Table 5 – Scoring Validation Exceeds/Substantially Exceeds*.

January 18, 2019

Three separate Meetings were held.

Evaluation Committee Meeting #1 at 10:30 AM

Attendees: Sheila Platts, Melanie Bush, Tabitha Bryant (by phone), Cathy Pace, Amanda Van Vleet, Sabrena Lea, Patrick Doyle, Leadership Mona Moon, Legal Counsel Lotta Crabtree (part phone and in-person), SME Kelsi Knick, Kimberley Kilpatrick and Gregory Sligh.

1. Posed the Confidentiality and Conflict of Interest question to the Committee – no conflicts.
2. United submitted their response to the Clarification #2 request before the 9:00 a.m. deadline. See *Table 2 – Offeror Clarifications* for additional information.
3. The Committee reviewed United's Clarification #2 response. No scores were changed based on the Clarification.
4. The Committee having completed a review and scoring of all questions agreed to meet at 12:00 PM to review the scores for the first time with the understanding that quality assurance activities were on-going and scores would not be final until that process is complete.

Evaluation Committee Meeting #2, 12:00 PM

Attendees: Sheila Platts, Melanie Bush, Tabitha Bryant (by phone), Cathy Pace, Amanda Van Vleet, Sabrena Lea, Patrick Doyle, Leadership Mona Moon, Legal Counsel Lotta Crabtree, Kimberley Kilpatrick and Gregory Sligh.

1. Posed the Confidentiality and Conflict of Interest question to the Committee – no conflicts.
2. A summary of the scores was reviewed and discussed.

Evaluation Committee Meeting #3 at 2:30 PM

Attendees: Sheila Platts, Melanie Bush, Tabitha Bryant (by phone), Cathy Pace, Amanda Van Vleet, Sabrena Lea, Patrick Doyle, Leadership Mona Moon, Legal Counsel Lotta Crabtree (by phone), Leadership Jay Ludlam (briefly by phone), SME Sarah Gregosky, Kimberley Kilpatrick and Gregory Sligh.

1. Posed the Confidentiality and Conflict of Interest question to the Committee – no conflicts.

2. A summary of the scores was reviewed and discussed.
3. The Committee completed a quality assurance review to ensure the scores of Exceeds/Substantially Exceeds were clear, consistent across all Offerors and sufficiently detailed.
4. The next step of the quality assurance process is for Lotta Crabtree to review the scoring of Offeror Client References.

January 22, 2019

Evaluation Committee Meeting

Attendees: Sheila Platts, Amanda Van Vleet, Melanie Bush (by phone), Tabitha Bryant, Cathy Pace, Sabrena Lea, Patrick Doyle, Leadership Mona Moon, Leadership Jay Ludlum, Legal Counsel Lotta Crabtree, SME Sarah Gregosky, Kimberley Kilpatrick and Gregory Sligh.

1. Posed the Confidentiality and Conflict of Interest question to the Committee – no conflicts.
2. As part of the quality assurance process, Kimberley Kilpatrick presented to the Committee her findings when performing a validation in the scoring tools on January 19.
 - a. **AmeriHealth:** Question #47 was scored as “exceeds” in the PHP Consensus Scoring Excel file incorrectly, as the score by the Committee was “meets.” Correction adjusted AmeriHealth from 711.25571 to 706.66204.
 - b. **CCH:** Use Case Scenario #6 in the PHP Consensus Scoring Excel file drop-down box was blank and did not calculate the points for “meets.” Updated box to reflect “meets” and calculate the points. Client Reference #1 had the information correct in the notes, but the drop-down boxes were blank and did not calculate the points for “relevant” and “satisfied.” Correction adjusted CCH from 612.64969 to 628.39969.
 - c. **WellCare:** Use Case Scenario #4 in the PHP Consensus Scoring Excel file drop-down box was blank and did not calculate the points for “meets.” Updated the box to reflect “meets” and calculate the points. This correction adjusted WellCare from 731.99304 to 736.19304.
 - d. Committee confirmed scores and supporting reasons for corrections in the PHP Consensus Scoring Excel file. Corrections made.
3. The Committee also discussed the findings of the overall review of Offeror Client References conducted by Lotta Crabtree.
 - a. The Committee did not initially score BCBS’s reference from BlueChoice Health Plan of South Carolina because they determined it was not a “client” reference (See December 19, #4). However, a reference for Aetna from Mercy Care Plan was scored. Legal Counsel presented to the Committee that the relationship between BlueChoice Health Plan and Amerigroup and that of Aetna and Mercy Care appeared similar.
 - b. Following discussion by the Committee it was determined that the reference for Amerigroup Partnership Plan, LLC from BlueChoice Health Plan of South Carolina should be scored for BCBS and the scoring was updated accordingly.

3. A summary of the scores was reviewed and discussed, and the Committee determined its award recommendation to be as follows, based on the scores:
 - a. AmeriHealth Caritas North Carolina, Inc.
 - b. Blue Cross and Blue Shield of North Carolina
 - c. UnitedHealthcare of North Carolina, Inc.
 - d. WellCare of North Carolina
6. The Committee discussed whether to recommend award of a regional contract. Only two Offerors are eligible for regional contracts, CCH and Optima. CCH and Optima are the lowest scoring Offerors by a margin of more than 75 points relative to the fourth highest scoring Offeror. Optima's total score indicates the Offeror, on average, failed to achieve the threshold to "meet expectations," i.e. 60% of the total possible points or 615. Awarding a contract to CCH would result in making an award over higher scoring and more technically capable Offerors. While those higher scoring Offerors are not eligible for regional contracts, the Committee did not recommend an award to CCH given their significantly lower technical score.
7. While the Committee reached consensus on the award recommendation based on the scores, the recommendation was subject to change pending completion of all QA activities and resulting final scores. A final comparison of the handwritten scores and related notes (Scoring Notebook) in the form of *Attachment # 7 PHP Scoring Guide* with the Excel Scoring Spreadsheet, *Attachment #11 PHP Consensus Scoring Excel File*, was still required.

January 24, 2019

Evaluation Committee Meeting

Attendees: Tabitha Bryant, Cathy Pace, Amanda Van Vleet, Sheila Platts (by phone), Melanie Bush (by phone), Sabrena Lea (by phone), Patrick Doyle (by phone), Leadership Mona Moon, Legal Counsel Lotta Crabtree, SME Sarah Gregosky, Kimberley Kilpatrick and Gregory Sligh.

1. Posed the Confidentiality and Conflict of Interest question to the Committee – no conflicts.
2. Meeting called to discuss the final quality review activity of the scores conducted to ensure consistency and accuracy.
3. Sarah Gregosky and Greg Sligh compared the Scoring Notebook with the Excel Scoring Spreadsheet. Three (3) inconsistencies were discovered for question 5., Attachment O. Offeror's Proposal and Response Table 3: Entities performing core functions or with proposed experience as follows:
 - a. BCBS had entity EyeMed Vision Care, LLC listed twice.
 - b. My Health was scored Experience: "Meets" for its entity Community Care Partners of Greater Mecklenburg. All other CCNC Networks were scored Experience: "Exceeds" for the same question.

STATE OF NORTH CAROLINA

IN THE OFFICE OF
ADMINISTRATIVE HEARINGS

COUNTY OF WAKE

Optima Family Care of North Carolina, Inc.,
Petitioner,

v.

North Carolina Department of Health and
Human Services, Mandy Cohen, M.D., MPH,
in her official capacity as Secretary of the
Department, and Dave Richard in his official
capacity as Deputy Secretary of the
Department for NC Medicaid,

Respondent,

and

WellCare of North Carolina, Inc., Blue Cross
And Blue Shield of North Carolina,
AmeriHealth Caritas of North Carolina, Inc.,
UnitedHealthCare of North Carolina, Inc.,
Carolina Complete Health, Inc., and North
Carolina Provider owned Plans, Inc. d/b/a My
Health by Health Providers,

Respondent-Intervenors.

19 DHR 01959

North Carolina Provider Owned Plans, Inc.
d/b/a My Health By Health Providers,
Petitioner,

v.

North Carolina Department of Health and
Human Services,

Respondent,

and

UnitedHealthCare of North Carolina, Inc.,
Blue Cross And Blue Shield of North
Carolina, WellCare of North Carolina, Inc.,
AmeriHealth Caritas of North Carolina, Inc.,
Carolina Complete Health, Inc., and Optima
Family Care of North Carolina, Inc.,

Respondent-Intervenors.

19 DHR 02032

Aetna Better Health of North Carolina, Inc.,
d/b/a Aetna Better Health of North Carolina,
Petitioner,

v.

State Of North Carolina Department of Health
and Human Services – Division of Health
Benefits,

Respondent,

and

WellCare of North Carolina, Inc., Blue Cross
And Blue Shield of North Carolina,
AmeriHealth Caritas of North Carolina, Inc.,
UnitedHealthCare of North Carolina, Inc.,
Carolina Complete Health, Inc., and North
Carolina Provider Owned Plans, Inc. d/b/a My
Health By Health Providers,
Respondent-Intervenors.

19 DHR 02194

Carolina Complete Health, Inc.,
Petitioner,

v.

North Carolina Department of Health and
Human Services,

Respondent,

and

AmeriHealth Caritas of North Carolina, Inc.,
and North Carolina Provider Owned Plans,
Inc. d/b/a My Health By Health Providers,
Respondent-Intervenors.

19 DHR 03352

**RESPONDENT’S MEMORANDUM IN OPPOSITION TO AETNA BETTER HEALTH
OF NORTH CAROLINA, INC.’S MOTION AND MEMORANDUM FOR LEAVE TO
AMEND ITS PETITION FOR A CONTESTED CASE HEARING**

Respondent, the North Carolina Department of Health and Human Services (“the Department”), submits this Memorandum in Opposition to Petitioner Aetna Better Health of North Carolina, Inc. d/b/a Aetna Better Health of North Carolina’s (“Aetna”) Motion and Memorandum for Leave to Amend its Petition for a Contested Case Hearing (“Motion”), filed September 19, 2019. Pursuant to 26 NCAC 03 .0101(a) and N.C. Gen. Stat. § 1A-1, Rule 15, and for the reasons

set forth below, the Department respectfully requests this Tribunal to issue an order denying Aetna's Motion.

I. RELEVANT BACKGROUND AND SUMMARY OF ARGUMENT

In October 2018, Aetna, along with seven other offerors, submitted a proposal to the Department in response to the Department's request for proposal #30-190029-DHB for Prepaid Health Plan Services (the "RFP"). From October 2018 through January 2019, the Department engaged in an exhaustive, thorough, comprehensive, and fair evaluation process of all eight proposals received in response to the RFP. On February 4, 2019, the Department announced its award of four statewide contracts and two regional contracts. Aetna was not awarded a statewide contract and was not eligible for (nor did it seek) any regional contracts.

A few hours after the Department announced its awardees, Aetna began seeking information from the Department regarding the Department's procurement decision. Aetna received extensive information from the Department on February 7, 2019, filed its protest with the Department on March 5, 2019, and filed its contested case on April 16, 2019. Over seven months after receiving information detailing the Department's scoring methodology and chronology of decisions made during the scoring process, over six months after lodging its Protest with the Department, over five months after it filed its contested case, and with less than two weeks prior to the close of discovery, Aetna filed its Motion to amend its petition on September 19, 2019. Despite its attempts to do so, Aetna has failed to adduce evidence in discovery to support the claims alleged in its original Petition and now seeks to amend its Petition to allege two new claims set forth in its proposed Amended Petition even though the deadline for discovery is expiring today. The Motion should be denied.

First, Aetna seeks to pursue a claim that the Evaluation Committee should not have scored a reference submitted in support of Blue Cross and Blue Shield of North Carolina's ("BCBSNC") proposal in response to the RFP on the grounds that the reference was not sufficiently independent to constitute a valid client reference. *See* Motion, Ex. 1, proposed Amended Petition, ¶ 5 and § F at pp. 30-33. This is the only complaint that Aetna raises, or has ever raised, regarding the scoring of BCBSNC's proposal.

The Tribunal should deny Aetna's Motion as to this new claim because it would be futile to allow Aetna to pursue it. The decision to score the reference was clearly and objectively the correct decision, and Aetna adduced no evidence in discovery, submitted no affidavits or other evidence in support of its Motion, or alleged facts in its proposed Amended Petition that would plausibly support a finding that the decision to score the reference was incorrect. The form for offerors to submit with their proposals regarding references states the reference can be on behalf of the offeror or one of its contractors or joint venture partners. BCBSNC submitted information about its key contractor for Core Medicaid Functions, which has extensive experience throughout the country administering Medicaid managed care contracts: Amerigroup Partnership Plan, LLC ("Amerigroup"). The source of the reference was BlueChoice Health Plan of South Carolina, Inc. ("BlueChoice of SC"), which had a contract with Amerigroup. BlueChoice of SC sent the Department a favorable reference regarding Amerigroup, and the Evaluation Committee scored it.

Publicly available records make clear that BCBSNC and BlueChoice of SC are independently operated entities. They both have trademark licenses and agreements with the Blue Cross Blue Shield Association, but BCBSNC is a non-profit, and BlueChoice of SC is a subsidiary of Blue Cross Blue Shield of South Carolina, which is a mutual company. BCBSNC and BlueChoice of SC have no overlapping ownership or control, and BlueChoice of SC would not

stand to benefit from a favorable reference on behalf of Amerigroup. Amerigroup is owed by Anthem, Inc., a publicly traded for profit entity. Amerigroup has contracts with other independent Blue Cross entities, but it is independently owned and operated, and there is no overlapping ownership or control between it and BCBSNC or BlueChoice of SC. Aetna utterly fails to provide any analysis or evidence that could support a conclusion that the reference was not sufficiently independent to constitute a valid client reference.

Accordingly, the reference from BlueChoice of SC regarding Amerigroup was sufficiently independent to qualify as a valid client reference, and Aetna has submitted no evidence and makes no specific factual allegation to the contrary. Further, a reference regarding an Aetna contractor (which is also an Aetna affiliate) was sought from an entity that is operated by the Aetna contractor/affiliate, thus, there is a similar issue whether the reference is sufficiently independent to qualify as proper client reference. If the Evaluation Committee's decision to score the reference in support of the proposal of BCBSNC is revisited, the decision to score the Aetna reference should also be reviewed to ensure that the same standard is applied to both. Applying the same, consistent standard to both BCBSNC's reference and Aetna's reference leads to the same result: BCBSNC has more points than Aetna, and Aetna remains the fifth place statewide offeror.

Lacking any evidence to support a finding that the BCBSNC reference was not sufficiently independent to constitute a valid client reference, Aetna, in a desperate attempt to support its Motion regarding this issue, makes inappropriate and unsubstantiated personal attacks against Department employees involved with this procurement and now alleges a grand conspiracy by Department employees to give a contract to BCBSNC. As discussed herein, the allegations are baseless. Members of the Evaluation Committee had no legal conflict of interest, they appropriately disclosed relevant information to the Department, they stated they could be fair and

impartial, Department management exercised its discretion in deciding they could serve on the Evaluation Committee, there is no evidence any member acted in an unfair and impartial manner, and all seven members of the Evaluation Committee reached a consensus as to the rating for each response to each Evaluation Question from each of the Offerors, including client references – and they made the objectively correct decision regarding the BCBSNC reference.

Not surprisingly, given the size and complexity of this procurement, the Department conducted an “end to end” quality assurance process before finalizing any award recommendations to correct errors and to ensure consistent, reasonable, and fair standards had been applied to all proposals. The Department’s process was fully appropriate, and the Department remains confident in the work and decisions reached by the Evaluation Committee. Aetna has failed to adduce evidence or allege specific facts to support a conclusion to the contrary.

Aetna’s Motion should also be denied as to the BCBSNC reference issue because of Aetna’s unreasonable delay in pursuing it, its failure to exhaust its administrative remedies, and the prejudice that would result to the Department and other parties if the motion was granted. All relevant information regarding the reference issue was known by Aetna and contained in documents provided to it before it submitted its protest to the Department and before it filed its original Petition. The Department and the parties would also be prejudiced if the Motion is granted. For example, the time for discovery has expired, and the parties are unable to conduct discovery to further demonstrate that the BCBSNC reference was sufficiently independent to constitute a valid client reference and that the Aetna reference was handled on a consistent basis.

Second, and although Aetna does not mention it in its Motion, the proposed Amended Petition would also add a claim that Offeror UnitedHealthCare of North Carolina, Inc. (“United”) should not have been given points by the Evaluation Committee in response to Evaluation

Question 11 regarding a commitment to participate in the Federally Facilitated Marketplace because, as disclosed by United after it had been awarded a contract under this procurement, United intends to fulfill the commitment through an affiliated United entity. *See* Motion, Ex. 1, proposed Amended Petition, § G at pp. 33-34. Aetna's Motion regarding this issue should be denied because it would be futile to allow Aetna to pursue it. Even if all points awarded United regarding its response to this Evaluation Question were taken away, it would still be one of the top four offerors; thus, it would not change the result of the evaluation process. Further, Aetna has not demonstrated it would be inappropriate to allow United to fulfill the commitment through an affiliate or that doing so would be inconsistent in how other offerors were scored. The Motion should also be denied regarding this issue because of Aetna's unreasonable delay in pursuing it, its failure to exhaust its administrative remedies, and the prejudice that would result to the Department and other parties if the motion was granted at this late date.

II. LEGAL STANDARD

When not otherwise addressed in the North Carolina Administrative Code, the North Carolina Rules of Civil Procedure generally apply to contested cases held before the Office of Administrative Hearings. 26 NCAC 03 .0101(a). Under Rule 15(a) of the North Carolina Rules of Civil Procedure,

A party may amend his pleading once as a matter of course at any time before a responsive pleading is served or, if the pleading is one to which no responsive pleading is permitted..., he may so amend it at any time within 30 days after it is served. Otherwise a party may amend his pleading only by leave of court or by written consent of the adverse party; and leave shall be freely given when justice so requires.

N.C.G.S. 1A-1, Rule 15(a). "A motion to amend, however, is addressed to the sound discretion of the trial judge, whose ruling will not be disturbed absent proof that the judge manifestly abused that discretion." *Walker v. Sloan*, 137 N.C. App. 387, 402, 529 S.E.2d 236, 247 (2000); *see also*

Caldwell's Well Drilling, Inc. v. Moore, 79 N.C. App. 730, 731, 340 S.E.2d 518, 519 (“[A] motion to amend a complaint ... is addressed to the sound discretion of the trial judge and the denial of such motion is not reviewable on appeal absent a clear showing of abuse of discretion.”). Reasons justifying the denial of a motion to amend are (a) undue delay, (b) bad faith, (c) undue prejudice, (d) futility of amendment, and (e) repeated failure to cure defects by previous amendments. *Walker*, 137 N.C. App. at 402, 529 S.E.2d at 247.

III. ARGUMENT

A. Aetna’s Motion Should be Denied because the New Allegations are Ultimately Futile.

Futility is an established basis on which to deny a motion to amend a pleading. When an amendment would be futile in light of the propriety of a dispositive ruling on a party’s claim, denial of the motion to amend is proper. *N.C. Council of Churches v. State*, 120 N.C. App. 84, 93, 461 S.E.2d 354, 360 (1995), *aff’d*, 343 N.C. 117, 468 S.E.2d 58 (1996); *see also Orlando Residence, Ltd. v. Alliance Hospitality Management LLC*, 2018 NCBC 132, ¶¶ 38-39, 2018 WL 6728490 (Sup. Ct. of N.C., Business Court Dec. 20, 2018) (applying Rule 12(b) motion to dismiss standard to futility analysis).

a. New Allegations Regarding the Scoring of the BCBSNC Reference. Aetna’s addition of the new allegations regarding the scoring of the BCBSNC reference would be futile because Aetna has not presented evidence or made specific factual allegations in its proposed Amended Petition to create a plausible basis for or to support a finding that the BCBSNC reference was not sufficiently independent to be scored as a valid client reference.

The Department appropriately scored the BCBSNC reference from BlueChoice of SC. Each offeror was asked for four client references “for which it has provided services of similar size and scope to that requested herein.” Affidavit of Kimberley Rene Kilgore-Kilpatrick

(“Kilpatrick Aff.”), attached hereto at Exhibit 1, ¶ 11 and Ex. F thereto, p. NCDHHS-0013347. The Department further instructed offerors that it “prefer[red] at least three (3) references from state Medicaid programs. If Three (3) state Medicaid programs are not provided, Offeror must include a statement explaining why. The Department may take this into consideration when scoring the Offeror’s Client References.” *Id.* Offerors were permitted to give references for the offeror’s subcontractors or other partners. The Department’s instructions state: “The Offeror should indicate in the Offeror Name field the actual organization that held the contract with the submitted client reference (e.g., the Offeror, one of the Offeror’s subcontractors, joint venture partner) and state the relationship to the Offeror if applicable.” *Id.*

As part of its RFP response, BCBSNC submitted four client references: (1) BlueChoice Health Plan of South Carolina, Inc. (BlueChoice of SC), a reference for BCBSNC’s subcontractor Amerigroup Partnership Plan, LLC; (2) Washington Health Care Authority, a reference for Amerigroup Washington, Inc., an affiliate of BCBSNC’s subcontractor Amerigroup Partnership Plan, LLC; (3) Georgia Department of Community Health, a reference for AMGP Georgia Managed Care Company, Inc., an affiliate of BCBSNC’s subcontractor Amerigroup Partnership Plan, LLC; and (4) Maryland Department of Health, a reference for Amerigroup Maryland, Inc., an affiliate of BCBSNC’s subcontractor Amerigroup Partnership Plan, LLC. Kilpatrick Aff., Ex. 1, ¶ 11 and Ex. F thereto.¹ The references from BlueChoice of SC and the Maryland Department of Health were returned by the respective clients; the other two references were not returned. Kilpatrick Aff., Ex. 1, ¶ 8 and Ex. D thereto, pp. NCDHHS-0030796-30797.

¹ Three of these four references were from state Medicaid programs: Washington, Georgia, and Maryland. *Id.*

The Evaluation Committee's Meeting Notes and Timeline track the Evaluation Committee's consideration of the BlueChoice of SC reference for BCBSNC. The undisputed evidence shows that on December 18, 2019, during the scoring of many of the various offerors' client references, the scoring members of the Evaluation Committee sought guidance "concerning BCBS's use of BlueChoice Health Plan of South Carolina." *Id.* at NCDHHS-0030783. The scoring members of the Evaluation Committee, through the contract lead Kimberley Kilpatrick, received advice "to be consistent in determining if the reference was a client reference and relevant to the scope of services." *Id.* at NCDHHS-0030784. The next day, December 19, 2019, and based on the advice "to be consistent in their consideration, treatment and scoring of references," the scoring members of the Evaluation Committee agreed "to not score the reference[] as the BCBS reference was deemed not a 'client reference.'" *Id.*² Consequently, the reference from BlueChoice of SC was not scored in December 2018.

By January 14, 2019, the Evaluation Committee had begun "several quality assurance reviews to ensure consistency and accuracy of the score." *Id.* at NCDHHS-0030787-30788. On January 15, 2019, the Evaluation Committee's Meeting Notes and Timeline note: "As part of the quality assurance process, Mona Moon inquired about the status of outstanding references." *Id.* at NCDHHS-0030788.³ Multiple references were still outstanding, and, because a firm deadline had not been previously given for the return of references, a decision was made to issue a final request

² Similarly, the chart of client references included in the Meeting Notes and Timeline states that this reference was "not scored as it was not considered to be an acceptable Client Reference because it came from BlueChoice HealthPlan of South Carolina and not the state of South Carolina." *Id.* at NCDHHS-0030796.

³ Ms. Moon is the COO of NC Medicaid and has many years of procurement experience. Excerpts of Mona Moon Deposition ("Moon Dep."), attached hereto as Exhibit 2, pp. 13, 46-47. Ms. Moon has explained the "end to end" quality assurance process that was followed in January 2019 examining all facets of the scoring and evaluation process. *Id.* pp. 95-96.

with a firm deadline for the return of references. *Id.* Also on January 15, 2019, Ms. Kilpatrick brought attention to the fact that the BCBSNC reference from BlueChoice of SC had been returned but not scored. Moon Dep., Ex. 2, pp. 139-144. Ms. Moon testified that “[i]f we’re not scoring something we received, I want to understand why and make sure that that’s a – an appropriate action, that we’re not overlooking something that the committee should be scoring.” *Id.* p. 139. On January 16, 2019, Ms. Moon “explained the process for the last request made for Offeror’s outstanding client references which were due no later than January 17 by 9:00 AM EST.” Kilpatrick Aff., Ex 1, ¶ 8 and Ex. D thereto, pp. NCDHHS-0030788. On January 18, 2019, it was noted that “[t]he next step of the quality assurance process is for Lotta Crabtree to review the scoring of Offeror Client References.” *Id.* at NCDHHS-0030790-30791. The scoring members of the Evaluation Committee met on January 22, 2019, and reviewed the overall review of Offeror Client References. At that meeting, and “following discussion by the Committee it was determined that the reference for Amerigroup Partnership Plan, LLC from BlueChoice Health Plan of South Carolina should be scored for BCBS.” *Id.* at NCDHHS-0030791.⁴

There is no genuine issue of material fact that the scoring members of the Evaluation Committee properly scored the BlueChoice of SC reference. The reference is for a subcontractor of BCBSNC. It is also from an independent entity. Although Aetna has alleged “the lack of a genuinely independent relationship between BlueCross BlueShield of South Carolina and Blue Cross and Blue Shield of North Carolina and its affiliate Amerigroup Partnership Plan, LLC,” Motion, Ex. 1, ¶ 143, no evidence exists to support this allegation, and Aetna has cited none in its

⁴ Similarly, the chart of client references included in the Meeting Notes and Timeline states that “[a]fter quality review check of all references it was determined that the reference from BlueChoice HealthPlan of South Carolina should be scored consistent with the scoring of other client references.” *Id.* at NCDHHS-0030796.

Motion. There is nothing in the BCBSNC reference form or the reference returned by BlueChoice of SC that states or could be construed to support a finding that the entities are not sufficiently independent to constitute a valid client reference. *See* Kilpatrick Aff., Ex 1, ¶¶ 11, 12 and Exs. F and G thereto. All evidence is that these are independent entities. Publicly available records make clear that BCBSNC and BlueChoice of SC are independently operated entities. *See, e.g.*, <https://www.bcbs.com/about-us/the-blue-cross-blue-shield-system>; *see also* Deposition Exhibit 436 (attached hereto as Exhibit 3); information regarding BCBSNC (attached hereto as Exhibit 4); information regarding BlueChoice of SC (attached hereto as Exhibit 5). They both have trademark licenses and agreements with the Blue Cross Blue Shield Association, but they are separate entities with no overlapping ownership or control. BCBSNC is a nonprofit. BlueChoice of SC, an affiliate of mutual insurance company BlueCross and BlueShield of South Carolina, headquartered in Columbia, South Carolina, would not stand to benefit from a favorable reference on behalf of Amerigroup. *See, e.g.* Exs. 3, 4, 5. Amerigroup is owned by Anthem, Inc., a publicly traded for profit entity. Amerigroup has contracts with other independent Blue Cross entities, but it is independently owned and operated, and there is no overlapping ownership or control between it and BCBSNC or BlueChoice of SC. *See* Excerpt of Anthem, Inc. 10-K for year ended Dec. 31, 2018, p. 3 (attached hereto as Exhibit 6).

Standing on its own, BCBSNC received 12.5 points from the scoring of the BlueChoice of SC reference, which is more than the difference between its score (712.22431) and Aetna's score (704.60144). Kilpatrick Aff., Ex. 1, ¶ 9 and Ex. E thereto, pp. NCDHHS-0030995, 30996, 31047. All of the evidence points to the objective propriety of the Evaluation Committee's decision to score the BCBSNC reference. The objective propriety of this decision is reinforced by the consistent treatment received by Aetna's own reference. Aetna provided a reference from Mercy

Care (Southwest Catholic Health Network Corporation d/b/a Mercy Care). In response to Evaluation Question 7, Aetna affirmed the following interrelationships among Mercy Care and other Aetna entities, including a key subcontractor of Aetna's, Aetna Medicaid Administrators, LLC:

Mercy Care is not owned by Aetna, Inc., but it *is managed by Aetna Medicaid Administrators LLC* (Aetna Medicaid Administrators), the same Aetna affiliate that will provide the majority of management services for Aetna Better Health of North Carolina. Aetna Medicaid Administrators provides plan management services to Mercy Care under a Plan Management Services Agreement (PMSA). Mercy Care, and not Aetna Medicaid Administrators, holds the Acute Care Contract directly with) [sic] Arizona's Medicaid agency, the Arizona Health Care Cost Containment System (AHCCCS). This reference is from Mercy Care's Board Chair for the work Aetna Medicaid Administrators performs as the plan administrator, and not from AHCCCS.

Deposition Exhibit 428 (attached hereto as Exhibit 7) (emphasis added).⁵ Although Aetna alleges that the relationship between Aetna and Mercy Care is not similar to the relationship between BlueChoice of SC and Amerigroup as assessed by the Department (Motion, Ex. 1, ¶ 146), it has not presented any facts for this Tribunal's consideration in support of its Motion to this end. If this Tribunal decides to revisit the reference in support of BCBSNC, it should also review the Aetna reference so that the same standard is applied to both. Applying the same, consistent standard to both BCBSNC's reference and Aetna's reference leads to the same result: BCBSNC has more points than Aetna, and Aetna remains the fifth place statewide offeror. Amending the petition with these allegations is futile.

In sum, the Evaluation Committee made the objectively correct decision in scoring the reference from BlueChoice of SC. The documentation about the BlueChoice of SC reference is

⁵ Aetna provided this same information in its reference form regarding the Mercy Care reference but designated the reference form and Mercy Care's response as confidential and proprietary.

clear. Aetna has alleged no facts or presented any evidence to the contrary. Consequently, allowing the amended petition to add these allegations would be futile.

b. New Allegations Regarding Conflicts. As discussed above, Aetna has no evidence that the BCBSNC reference from BlueChoice of SC was not sufficiently independent to constitute a valid client reference. However, Aetna, in a desperate attempt to support its Motion regarding this issue, makes inappropriate and unsubstantiated personal attacks against Department employees involved with this procurement. The grand conspiracy alleged by Aetna has no grounding in the evidence, and these allegations are baseless.

First, the members of the Evaluation Committee had no legal conflict of interest. Under North Carolina law, a conflict with regard to public contracting exists where employees or spouses derive a direct benefit from the contract. A direct benefit is where the person owns more than ten percent of the entity awarded the contract, derives income or commission directly from a contract, or acquires property under the contract. N.C.G.S. § 14-234(a1)(4). Aetna has not alleged any facts that would constitute a legal conflict of interest by any member of the Evaluation Committee.

Second, Aetna misreads and misunderstands the Request for Information Confidentiality and Conflict of Interest Statement, which it attached as Exhibit C to its proposed Amended Petition. As the form itself suggests, it is a “Request for Information” about conflicts or potential conflicts. “Conflicts of Interest” is a defined term under Section B of that form. It states: “A Conflict of Interest, or the appearance of a Conflict of Interest, *may occur* if you are directly or indirectly involved with a person or an organization that has submitted a proposal for evaluation.” Ex. C to Aetna proposed Amended Petition, at NCDHHS-0033728 (emphasis added). Section B(1) then defines a Conflict of Interest for purposes of handling that issue with the contract leads and, if necessary, appropriate Department staff. *Id.* Section B(2) states that “[p]rior to reviewing

any proposals, you must inform the Contract Lead(s) of any Conflict of potential Conflicts of Interest with the associated procurement. *The Contract Lead(s) will work with the appropriate Department Staff to determine if you should serve as a member of the Committee.*” *Id.* (emphasis added). In other words, disclosure of a Conflict or potential Conflict of Interest is not an automatic disqualification. Instead, the form and disclosure requirement contained therein is designed to bring any associated relationships to the knowledge of the Department so that the Department can make a decision about whether or not the individual should serve as a member of the committee.⁶ The standard for a legal conflict of interest is stated in N.C.G.S. § 14-234(a1)(4). The form titled “Request for Information Confidentiality and Conflict of Interest Statement” simply solicits information, and the Department can decide after receiving that information whether it is appropriate for a given individual to serve.

Here, Aetna has identified no legal conflict held by any member of the Evaluation Committee. At most, Aetna alleges an instance of a relationship that should be disclosed for Department consideration under the terms of the Request for Information Confidentiality and Conflict of Interest Statement. This relationship—between a scoring member of the Evaluation Committee and an employee of BCBSNC—was, in fact, disclosed to Department leadership before the Evaluation Committee began its work. Department leadership considered the information and found it appropriate for this scoring member to serve. This member of the Evaluation Committee is not married, there is no ownership interest in BCBSNC (which is a nonprofit), and there is no evidence of a direct financial benefit from this contract that would accrue to either the scoring member of the Evaluation Committee nor this BCBSNC employee. Indeed, this BCBSNC

⁶ Deposition transcripts from multiple depositions taken over the last two weeks are not yet available. The Department will supplement the record with relevant portions of the deposition testimony when those transcripts are prepared and available.

employee does not work in Medicaid for BCBSNC. Excerpts of Jay Ludlam Deposition, attached hereto as Exhibit 8, pp. 367-369.⁷ The scoring member at issue affirmed that she could be fair and impartial, she had deep and relevant experience in her given subject matter, and her service was approved by the Assistant Secretary for Health Plans and Transformation before she began work on the Evaluation Committee. *Id.* There is no evidence that she did not serve in a fair and impartial manner, and there is no evidence that she raised or led the discussion regarding the BCBSNC reference issue. Further, under the consensus scoring method, all seven scoring members of the Evaluation Committee correctly agreed that the reference should be scored. There is simply no evidence that this scoring member ever acted in any way that was biased or inappropriate.

Aetna further alleges that Sarah Gregosky (misspelled Gregowski) was previously employed by BCBSNC and that this constitutes an improper conflict of interest. Motion, Ex. 1, ¶ 148. It does not. Ms. Gregosky worked for BCBSNC for about one year, leaving in October 2016. She did not do any Medicaid work while at BCBSNC. Deposition Exhibit 199 (attached hereto as Exhibit 10). Further, Aetna alleges that Ms. Gregosky “designed” the RFP. Motion, Ex. 1, ¶ 148. She did not. She took over the lead role in managing the development of the RFP, but the design of the RFP was a team effort. Indeed, Aetna has confirmed that it has no issues whatsoever with the RFP. May 15, 2019 Hearing Tr. p. 49:20-21 (“We [Aetna] don’t have a single issue with the RFP.”). Ms. Gregosky was not a scoring member of the Evaluation Committee, there is no evidence that she did not act in a fair and impartial manner at all times, and there is no evidence

⁷ Mr. Ludlam is the Assistant Secretary for Health Plans and Transformation for North Carolina’s Medicaid program. Deposition Exhibit 303 (attached hereto as Exhibit 9).

that she raised or voted on the BCBSNC reference issue. Quite simply, there is nothing close to a conflict with BCBSNC with regard to Ms. Gregosky.⁸

Aetna also misleadingly alleges that another scoring member of the Evaluation Committee, Sheila Platts, went to work for BCBSNC “almost immediately upon completing scoring.” This is incorrect. Ms. Platts left employment at the Department on July 12, 2019—more than five months after she finished her service on the Evaluation Committee—and did not even apply for the position at BCBSNC until May 2019. Excerpts of Sheila Platts Deposition, attached hereto as Exhibit 12, pp. 103, 107, 114. Ms. Platts does not work in Medicaid at BCBSNC. *Id.* pp. 14-16. This is simply not a conflict of interest or remotely close to one.

Aetna also insinuates that Secretary Cohen had a conflicts issue with BCBSNC. Motion, Ex. 1, ¶¶ 149, 150. Secretary Cohen had no conflict of interest. She had no legal conflict of interest, did not serve on the Evaluation Committee, and did not raise or even know about the BCBSNC reference issue nor did she participate in any decision to score it. There is simply no evidence of any improper relationship or improper communication with BCBSNC or any other offeror from the time the RFP was issued until the time of award in February 2019. Indeed, the New York Times article of August 26, 2019, is hearsay and, in fact, addresses the commercial lines of BCBSNC.

⁸ The industry for Medicaid professionals is small. Mr. Ludlam, now the Assistant Secretary for Medicaid Transformation in North Carolina, previously worked for both Aetna and WellCare in Missouri. Ex. 9, at NCDHHS-0177663-177664. Further, Aetna’s own Director of Business Development for Aetna Medicaid in North Carolina worked for the Department immediately before beginning to work for Aetna, ending work at the Department in late August 2016 and beginning work approximately a week later at Aetna in September 2016. Excerpts of A. Jamal Jones Deposition, attached hereto as Exhibit 11, pp. 43, 50-51. The job at Aetna paid more money than the job at the Department. *Id.* p. 51.

Finally, Aetna seems to confuse Mona Moon's (COO of Medicaid) and Lotta Crabtree's (Deputy General Counsel for the Department) past employment at the State Health Plan with working for BCBSNC as a *contractor* for the State Health Plan. *See* Motion, Ex. 1, ¶ 35. Ms. Moon and Ms. Crabtree worked for the State Health Plan—a division of the North Carolina Department of the State Treasurer.⁹ As state employees of the State Health Plan, they did not work for BCBSNC. *See, e.g. Ex. 2*, Moon Dep. pp. 176-180. There is nothing remotely close to a conflict of interest for Ms. Moon and Ms. Crabtree.

In sum, Aetna has not been able to adduce evidence to substantiate its claims in discovery. In a desperate attempt to save its case, it has alleged a new conspiracy theory grounded in insinuations and not in facts. There is no evidence that any member of the Evaluation Committee had any legal conflict of interest, there is no evidence that anything approaching a conflict of interest or a potential conflict of interest was not disclosed to Department leadership at the appropriate time, and there is no evidence whatsoever that any relationship with BCBSNC in any way impacted the decision to review the BCBSNC reference as part of the “end to end” quality assurance process or the ultimate, correct decision to score the reference.

c. New Allegations Regarding Evaluation Question 11. Aetna alleges for the first time that United should not be allowed to keep the 19.10075 points it earned for Evaluation Question 11. This allegation is futile. If allowed, there would be absolutely no change in result, and United would still receive a statewide contract. United scored 727.76474 points. Removing 19.10075 points would result in United having 708.6640 points, good for third place. Kilpatrick Aff., Ex. 1, ¶ 9 and Ex. E thereto, pp. NCDHHS-0030995, 30996. The statewide awardees would

⁹ <https://www.nctreasurer.com/inside-the-department/LearnAboutTheDepartment/Pages/default.aspx>.

not change. Allowing this amendment would be futile. Further, Aetna has not demonstrated it would be inappropriate to allow United to fulfill the commitment made in response to Evaluation Question 11 through an affiliate or that doing so would be inconsistent in how other offerors were scored. Indeed, as it pertains to Aetna, Aetna responded that Evaluation Question 11 did not apply to Aetna at all. Deposition Exhibit 427 (attached hereto as Exhibit 13). Accordingly, Aetna received no points for Evaluation Question 11. Kilpatrick Aff., Ex. 1, ¶ 9 and Ex. E thereto, p. NCDHHS-0030996.

B. Aetna’s Decision to Wait Until the End of Discovery to File this Motion Represents Undue Delay Under the Circumstances and, if Granted, Would Result in Unfair Prejudice.

“[A] trial court may appropriately deny a motion for leave to amend on the basis of undue delay where a party seeks to amend its pleading after a significant period of time has passed since filing the pleading and where the record or party offers no explanation for the delay.” *Rabon v. Hopkins*, 208 N.C. App. 351, 354, 703 S.E.2d 181, 184 (2010). “In deciding if there was undue delay, the trial court may consider the relative timing of the proposed amendment in relation to the progress of the lawsuit.” *Strickland v. Lawrence*, 176 N.C. App. 656, 667, 627 S.E.2d 301, 308 (2006). Undue delay exists in pursuing claims if the party “knew the relevant facts” at the time of the original filing and fails to offer a credible explanation for the delay in including those items in its pleading. *Media Network, Inc. v. Long Haymes Carr, Inc.*, 197 N.C. App. 433, 447, 678 S.E.2d 671, 681 (2009); *see also Micro Capital Investors, Inc. v. Broyhill Furniture Indus., Inc.*, 221 N.C. App. 94, 102, 728 S.E.2d 376, 382 (2012) (denying a motion to amend a complaint when the new claim to be asserted was available to the party “based on the information known to plaintiff at the time” of the earlier pleading). The party must give a credible and sufficient explanation for the delay. *See Media Network*, 197 N.C. App. at 447, 678 S.E.2d at 681 (describing requirement for

“credible explanation”); *Rabon*, 208 N.C. App. at 356, 703 S.E.2d at 185 (describing requirement for “sufficient explanation”).

Here, Aetna fails to offer a credible and sufficient explanation to explain its delay in raising its arguments about the impact of the Evaluation Committee’s (correct) decision to score the BCBSNC reference provided for Amerigroup from BlueChoice of SC. Aetna had all relevant information in early February 2019 to determine both the timing of the Evaluation Committee’s decision to score the BCBSNC reference and the impact of scoring that reference on the overall scoring of all offerors. Kilpatrick Aff., Ex. 1, ¶¶ 3, 4, 5, 6, 7, 8, and 9 and Exs. A, B, C, D, and E thereto. It is apparent from Aetna’s March 5, 2019 protest letter that Aetna scoured the consensus scoring sheet and other materials it received in February 2019 to attack the scoring decisions of the Evaluation Committee. Deposition Exhibit 430 (attached hereto as Exhibit 14). By way of just one of many examples, Aetna calculated scoring decisions out to four and five decimal places and deconstructed the scoring of one of several aspects for one of multiple subcontractors to attack the Evaluation Committee’s scoring of Evaluation Question 5. *Id.* at pp. 4-6. It is not credible to suggest that Aetna was unaware of the mathematical value of the scoring of any reference as it prepared its March 5, 2019 protest letter. At no place in the March 5, 2019 protest letter, the April 4, 2019 protest meeting and presentation, or Aetna’s April 16, 2019 Petition for a contested case did Aetna *ever* allege any concern with the Evaluation Committee’s January 22, 2019 decision to score the BCBSNC reference. *See, e.g.* Ex. 13; Deposition Exhibit 431 (attached hereto as Exhibit 15).

Attachment #4 Meeting Notes and Timeline was included in the information Aetna received on February 7, 2019. Kilpatrick Aff., Ex. 1, ¶¶ 4, 5, 6, 7, and 8. That document reveals that on December 18 and 19, 2018, the Evaluation Committee considered whether or not to score

the BCBSNC reference for Amerigroup from BlueChoice of SC, ultimately coming to the consensus decision on December 19, 2018, not to score the reference because it was deemed not to be a valid client reference. *Id.* at ¶ 8 and Ex. D thereto, pp. NCDHHS-0030783-30784. That document also reveals that one month later on January 18, 2019, the Evaluation Committee met three times. At the 10:30 AM meeting, the Evaluation Committee “completed a review and scoring of all questions” and then “agreed to meet at 12:00 PM to review the scores for the first time with the understanding that quality assurance activities were on-going and scores would not be final until that process is complete.” *Id.* at NCDHHS-0030790. The Evaluation Committee met at 12:00 PM, and “[a] summary of the scores was reviewed and discussed.” *Id.*¹⁰ The Evaluation Committee met again at 2:30 PM, and again “[a] summary of the scores was reviewed and discussed.” *Id.* at NCDHHS-0030790-30791. Next, “[t]he Committee completed a quality assurance review to ensure the scores of Exceeds/Substantially Exceeds were clear, consistent across all Offerors and sufficiently detailed.” *Id.* at NCDHHS-0030791. The last item for that meeting states “[t]he next step of the quality assurance process is for Lotta Crabtree to review the scoring of Offeror Client References.” *Id.* The Evaluation Committee next met on January 22, 2019. *Id.* After a presentation regarding a validation of the scoring tool “[a]s part of the quality assurance process,” the Evaluation Committee next “discussed the findings of the overall review of Offeror Client References.” *Id.* The following entries describe this discussion and the resulting decision of the Evaluation Committee:

¹⁰ It is neither uncommon nor improper for an evaluation committee to see interim scoring results during the course of the evaluation process.

- a. The Committee did not initially score BCBS's reference from BlueChoice Health Plan of South Carolina because they determined it was not a "client" reference (See December 19, #4). However, a reference for Aetna from [REDACTED] was scored. Legal Counsel presented to the Committee that the relationship between BlueChoice Health Plan and Amerigroup and that of Aetna and [REDACTED] appeared similar.
- b. Following discussion by the Committee it was determined that the reference for Amerigroup Partnership Plan, LLC from BlueChoice Health Plan of South Carolina should be scored for BCBS and the scoring was updated accordingly.

Id. As a result, the scores were updated, reviewed, and discussed, "and the Committee determined its award recommendation to be as follows, based on the scores:"

- a. AmeriHealth Caritas North Carolina, Inc.
- b. Blue Cross and Blue Shield of North Carolina
- c. UnitedHealthcare of North Carolina, Inc.
- d. WellCare of North Carolina

Id. at NCDHHS-0030792.

Aetna thus knew in February 2019 that on January 22, 2019, the Evaluation Committee scored a reference from BCBSNC. Aetna also knew in February 2019 that, at 5% of 1000 points, the references for each offeror were worth a total of 50 points. Aetna knew that four references were sought for each offeror. *Id.* at NCDHHS-0030794-30802. Dividing 50 by 4 reveals the ultimate value of a single reference to be 12.5 points. Aetna also knew in February 2019 that BCBSNC had been awarded 25 total points for its references (*Id.* at ¶ 9 and Ex. E thereto, p. NCDHHS-0030996), that it had been awarded 12.5 points for each reference that was returned (*Id.* p. NCDHHS-0031047), and that BCBSNC had two of four references returned, with two unreturned (*Id.* at ¶ 8 and Ex. D thereto, pp. NCDHHS-0030796-30797). Aetna also knew that the final point difference between it and BCBSNC was 7.6229 points (BCBSNC at 712.22431 – Aetna at 704.60144 = 7.6229 points). *Id.* p. NCDHHS-0030793. As this point difference is less than

12.5 points, it is not credible for Aetna to claim that it did not have the information necessary to protest this scoring decision at the time of its protest lodged on March 5, 2019.¹¹

Undue delay is also contextual. *See, e.g. Strickland*, 176 N.C. App. at 667, 627 S.E.2d at 308 (“[T]he trial court may consider the relative timing of the proposed amendment in relation to the progress of the lawsuit.”). Undue delay has been found when there was a three month delay of when the information became known and the motion for leave to amend. *Media Network*, 197 N.C. App. at 447, 678 S.E.2d at 681. Here, Aetna waited until just 11 days before discovery was to close to file its Motion despite knowing about the scoring decision and its impact before it filed its protest letter in March 2019 (more than six months prior to this Motion) or its petition for a contested case hearing in April 2019 (more than five months prior to this Motion).¹²

¹¹ Aetna, like all offerors, was instructed in the RFP to adhere to specific guidelines and procedures if it wished to protest a contract resulting from the RFP. “If an Offeror wishes to protest a Contract resulting from this solicitation that is awarded by the Department, the Offeror shall submit a written request addressed to contact identified in *Section II.E.6 Proposal Submission and Number of Copies*. The protest request must be received in the proper office within thirty (30) calendar days from the Contract Award. *Protest Letters shall contain specific grounds and reasons for the protest, how the protesting party was harmed by the award made and any documentation providing support for the protesting party’s claims*. ... All protests will be handed following the process defined in North Carolina Administrative Code, 01 NCAC 05B.1519, but will be administered by Department of Health and Human Services personnel.” Deposition Exhibit 429, attached hereto as Exhibit 16; RFP § II.G.6 (emphasis added). Aetna chose to omit the specific grounds of scoring the BCBSNC reference and the scoring of United’s response to Evaluation Question 11 from its protest. As these grounds come more than 30 days after the contract award and have not been raised to the agency, it is improper to do so at this time and in this manner. *See, e.g. Nailing v. UNC-CH*, 117 N.C. App. 318, 451 S.E.2d 351 (1994). Aetna’s failure to exhaust its administrative remedies further requires the denial of its Motion. *See, e.g. Abrons Family Practice & Urgent Care, PA v. N.C. Dep’t of Health & Human Servs.*, 370 N.C. 443, 447, 810 S.E.2d 224, 228 (2018).

¹² Aetna misleadingly suggests in its Motion that it first learned that Aetna was at one point prior to the completion of the quality assurance process in fourth place, and it learned this very recently during discovery. Motion pp. 4-5. Given the material available to Aetna in February 2019, this is not a credible or sufficient explanation for why Aetna did not include these allegations in its protest or its original Petition. Further, Aetna alleges that the Department failed to properly disclose the information on which it relies and has not explained why it did not disclose certain information earlier. This is incorrect. At all times during the document production process, the Department reiterated to Aetna and other parties that various documents, including some native Excel

Aetna's motion to amend its petition comes at a time that is "rather late in the case," and should be denied. *Delta Envtl. Consultants of N.C., Inc. v. Wysong & Miles Co.*, 132 N.C. App. 160, 166, 510 S.E.2d 690, 694 (1999). Aetna's calculated decision to wait until this point in the litigation to make its Motion works unfair prejudice on the Department and the other parties. The time for discovery is expiring today, and the parties are unable to conduct discovery to further demonstrate that the BCBSNC reference was sufficiently independent to constitute a valid client reference and that the Aetna reference was handled on a consistent basis. The Department and the parties are also prejudiced by not being able to conduct discovery regarding United's proposal to fulfill the commitment in Evaluation Question 11 through an affiliate or that doing so would be inconsistent in how other Offerors were scored.

IV. CONCLUSION

For the reasons stated above, Aetna's Motion for Leave to Amend Its Petition for a Contested Case Hearing should be denied.

[Signature Block to Follow on Next Page]

spreadsheets, contained information that had been designated proprietary by one or more offerors and could not be produced without confidentiality protections nor could they be produced at all in the native format requested. The Tribunal entered a Protective Order on September 3, 2019. One day later on September 4, 2019, the Department excerpted a pdf of a native Excel spreadsheet that contains protected information (and was thus subject to the Protective Order) and produced a portion of that spreadsheet that does not contain protected information to Aetna.

Respectfully submitted,

JOSHUA H. STEIN ATTORNEY GENERAL

By: _____

Colleen M. Crowley, N.C. State Bar No. 25375

John R. Green, Jr., N.C. State Bar No. 19040

Special Deputy Attorney Generals

N.C. Dept. of Justice

Post Office Box 629

Raleigh, NC 27602

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Facsimile: (919) 716-6759

ccrowley@ncdoj.gov

jgreen@ncdoj.gov

HAYNSWORTH SINKLER BOYD, P.A.

By: s/ Elizabeth H. Black

Robert Y. Knowlton, SC Bar No. 3589

Elizabeth H. Black, SC Bar No. 76067

1201 Main Street, 22nd Floor

Post Office Box 11889 (29211-1889)

Columbia, South Carolina 29201

(803) 779.3080

bknowlton@hsblawfirm.com

eblack@hsblawfirm.com

(admitted *pro hac vice*)

-and-

Boyd B. Nicholson, Jr., SC Bar No. 65387

Post Office Box 2048

Greenville, South Carolina 29602

(864) 240.3200

nnicholson@hsblawfirm.com

(admitted *pro hac vice*)

*Attorneys for Respondent North Carolina Department
of Health and Human Services*

October 4, 2019

Respondent's Memorandum in Opposition to
Aetna Better Health of North Carolina, Inc.'s
Motion and Memorandum for Leave to Amend
its Petition for a Contested Hearing

Exhibit 1

**Affidavit of Kimberley Rene
Kilgore-Kilpatrick
(Part 1 of 2)**

STATE OF NORTH CAROLINA

IN THE OFFICE OF
ADMINISTRATIVE HEARINGS

COUNTY OF WAKE

Optima Family Care of North Carolina, Inc.,
Petitioner,

v.

North Carolina Department of Health and
Human Services, Mandy Cohen, M.D., MPH,
in her official capacity as Secretary of the
Department, and Dave Richard in his official
capacity as Deputy Secretary of the
Department for NC Medicaid,
Respondent.

19 DHR 01959

and

WellCare of North Carolina, Inc., Blue Cross
And Blue Shield of North Carolina,
AmeriHealth Caritas of North Carolina, Inc.,
UnitedHealthCare of North Carolina, Inc.,
Carolina Complete Health, Inc., and North
Carolina Provider owned Plans, Inc. d/b/a My
Health by Health Providers,
Respondent-Intervenors.

North Carolina Provider Owned Plans, Inc.
d/b/a My Health By Health Providers,
Petitioner,

v.

North Carolina Department of Health and
Human Services,

Respondent.

19 DHR 02032

and

UnitedHealthCare of North Carolina, Inc.,
Blue Cross And Blue Shield of North
Carolina, WellCare of North Carolina, Inc.,
AmeriHealth Caritas of North Carolina, Inc.,
Carolina Complete Health, Inc., and Optima
Family Care of North Carolina, Inc.,
Respondent-Intervenors

Aetna Better Health of North Carolina, Inc.,
d/b/a Aetna Better Health of North Carolina,
Petitioner,

v.

State Of North Carolina Department of Health
and Human Services – Division of Health
Benefits,

Respondent,

and

WellCare of North Carolina, Inc., Blue Cross
And Blue Shield of North Carolina,
AmeriHealth Caritas of North Carolina, Inc.,
UnitedHealthCare of North Carolina, Inc.,
Carolina Complete Health, Inc., and North
Carolina Provider Owned Plans, Inc. d/b/a My
Health By Health Providers,
Respondent-Intervenors.

19 DHR 02194

Carolina Complete Health, Inc.,
Petitioner,

v.

North Carolina Department of Health and
Human Services,

Respondent,

And

AmeriHealth Caritas of North Carolina, Inc.,
and North Carolina Provider Owned Plans,
Inc. d/b/a My Health By Health Providers,
Respondent-Intervenors.

19 DHR 03352

AFFIDAVIT OF KIMBERLEY RENE KILGORE-KILPATRICK

I, Kimberley Rene Kilgore-Kilpatrick, upon first being duly sworn, depose and state as follows:

1. I am over the age of eighteen and have personal knowledge of the matters set forth in this affidavit, and I am duly qualified and authorized to give this affidavit.

2. I am employed by the North Carolina Department of Health and Human Services as Contracts & Compliance Specialist, Division of Health Benefits.

3. On February 4, 2019, I received the email attached hereto as Exhibit A from Debra G. Brutsman at Aetna requesting certain information regarding the selection of Medicaid health plans for Request for Proposal Number 30-190029-DHB for Prepaid Health Plan Services.

4. On February 6 and 7, 2019, I emailed with Ms. Brutsman and, at her direction, Daniel Baum of Troutman Sanders Strategies, regarding Mr. Baum's directive to retrieve a jump drive containing the documents requested by Aetna in Exhibit A. This email chain of February 6 and 7, 2019, is attached hereto at Exhibit B.

5. An envelope addressed to Mr. Baum containing this jump drive was left for pick up as indicated in Exhibit B, and the envelope was in fact picked up on February 7, 2019.

6. The contents of this jump drive are listed in Exhibit C hereto.

7. Item "4. A copy of the materials used during the evaluation process" in Exhibit C included the following items, which are followed by the Bates number reference as produced to all parties in these contested cases:

(a) Attachment #1 PHP Offerors Preproposal Conference Attendees List (begins at NCDHHS-0030752)

(b) Attachment #2 PHP Bid Opening Attendees List (begins at NCDHHS-0030755)

(c) Attachment #3 PHP Evaluation Kick-Off Meeting – Scoring Members (begins at NCDHHS-0030756)

(d) Attachment #4 PHP Evaluation Committee Meeting Notes and Timeline REDACTED (begins at NCDHHS-0030771)

(e) Attachment #5 PHP Evaluation Kick-Off Meeting – SMEs (begins at NCDHHS-0030865)

(f) Attachment #6 PHP Evaluation SME List (begins at NCDHHS-0030876)

(g) Attachment #7 PHP Scoring Guide (begins at NCDHHS-0030877)

(h) Attachment #8 Offeror Client Reference Questionnaire Template (begins at NCDHHS-0030944)

(i) Attachment #9 Question 11 Data R (begins at NCDHHS-0030946)

(j) Attachment #10 Question 11 NC County Exchange Enrollment R (begins at NCDHHS-0030982)

(k) Attachment #11 PHP Consensus Scoring Excel File REDACTED (begins at NCDHHS-0030994)

8. A true copy of Attachment #4 PHP Evaluation Committee Meeting Notes and Timeline REDACTED is attached hereto as Exhibit D. The only difference between Exhibit D

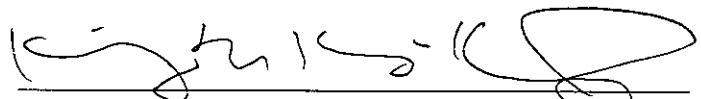
hereto and the version on the jump drive made available to Mr. Baum is that Exhibit D contains the Bates numbers applied to this document in these contested cases (NCDHHS-0030771-NCDHHS-0030864).

9. A true copy of the first 55 pages of Attachment #11 PHP Consensus Scoring Excel File REDACTED is attached hereto as Exhibit E (containing 3 pages of overall scoring and then full scoring analyses for offerors AmeriHealth Caritas North Carolina, Inc., Aetna Better Health of North Carolina, Inc. d/b/a Aetna Better Health of North Carolina, and Blue Cross and Blue Shield of North Carolina). The only difference between Exhibit E hereto and the version of these 55 pages on the jump drive made available to Mr. Baum is that Exhibit E contains the Bates numbers applied to this document in these contested cases (NCDHHS-0030994-NCDHHS-0031048).

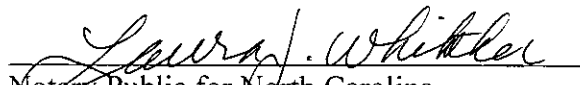
10. A better print-formatted version of Exhibit E has been produced beginning at NCDHHS-0212034. The content is the same in both Exhibit E and NCDHHS-0212034, but the print formatting changed the page numbers slightly.

11. A true copy of the redacted, publicly available form of the four client references provided by BlueCross BlueShield of North Carolina, produced in this litigation at NCDHHS-0013347-NCDHHS-0013395, is attached hereto as Exhibit F.

12. A true copy of my email correspondence with Timothy L. Vaughn of BlueChoice HealthPlan of SC wherein Mr. Vaughn returned BlueChoice HealthPlan of SC's completed reference questionnaire for Amerigroup Partnership Plan, LLC, including the completed reference questionnaire, is attached hereto as Exhibit G.


Kimberley Rene Kilgore-Kilpatrick

Sworn to before me this 3 day of
October, 2019


Notary Public for North Carolina
My Commission Expires: 10.22.22

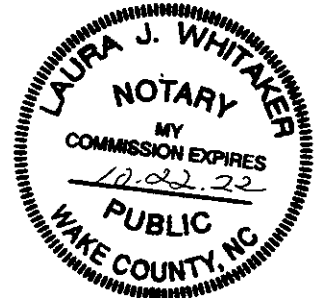


Exhibit A

From: Brutsman, Debra G <BrutsmanD@AETNA.com>
To: Kilpatrick, Kimberley R
CC: Markovich, Scott R; MBURFP
Sent: 2/4/2019 4:42:05 PM
Subject: [External] North Carolina: Information Request- RFP #30-190029-DHB
Importance: High

External email. Do not click links or open attachments unless you verify. Send all suspicious email as an attachment to report.spam@nc.gov
--

Dear Ms. Kilpatrick,

We respectfully request the following information at this time, regarding the selection of Medicaid health plans for RFP #30-190029-DHB:

- § Competitors Proposals
- § Scoring (overview and detailed)
- § Evaluators' notes

If you can send over what you have readily available now, we would appreciate receiving that first, to be followed by the rest as soon as it is available. Please note that we may have additional questions and do not wish to waive any rights to further requests for information. Should we have any additional requests for information, we will reach out to you directly.

For those items that aren't readily available, can you provide us with an estimated timeline to receive that information?

Thank you,

Debby Brutsman
Manager
Strategic Initiatives

M: 602-290-5186
E: brutsmand@aetna.com



This e-mail may contain confidential or privileged information. If you think you have received this e-mail in error, please advise the sender by reply e-mail and then delete this e-mail immediately. Thank you. Aetna

Exhibit B

From: Daniel Baum <Daniel.Baum@troutman.com>
To: Kilpatrick, Kimberley R
CC: Brutsman, Debra G; Jones, Arif J; Markovich, Scott R
Sent: 2/7/2019 12:01:44 PM
Subject: Re: [External] RE: RFP #30-190029-DHB Prepaid Health Plans
Attachments: image001.png

External email. Do not click links or open attachments unless you verify. Send all suspicious email as an attachment to report.spam@nc.gov
--

Thank you!

Daniel Baum

Director | State Affairs

Direct: [919.835.4183](tel:919.835.4183) | Mobile: [919.659.5444](tel:919.659.5444)

Daniel.Baum@troutmansanders.com

TROUTMAN SANDERS

TROUTMAN SANDERS STRATEGIES

305 Church at North Hills Street

Suite 1200

Raleigh, NC 27609

troutmansandersstrategies.com

On Feb 7, 2019, at 12:00 PM, Kilpatrick, Kimberley R <kimberley.kilpatrick@dhhs.nc.gov> wrote:

You may pick up at

Kirby Building

1985 Umstead Drive

Raleigh, NC 27603

There will be an envelope with the receptionist for you that will have Daniel Baum on the outside.

Kimberley Kilpatrick, Esq.

Contract and Compliance Specialist

Division of Health Benefits

NC Department of Health and Human Services

Office: 919-527-7015

Kimberley.Kilpatrick@dhhs.nc.gov

820 S. Boylan Ave.

McBryde Building

Raleigh, NC 27603

1950 Mail Service Center

Raleigh, NC 27699-1950

[Twitter](#) | [Facebook](#) | [YouTube](#) | [LinkedIn](#)

From: Daniel Baum <Daniel.Baum@troutman.com>

Sent: Wednesday, February 06, 2019 8:28 PM

To: Brutsman, Debra G <BrutsmanD@AETNA.com>; Kilpatrick, Kimberley R <kimberley.kilpatrick@dhhs.nc.gov>

Cc: Jones, Arif J <JonesA12@aetna.com>; Markovich, Scott R <MarkovichS@aetna.com>

Subject: [External] RE: RFP #30-190029-DHB Prepaid Health Plans

External email. Do not click links or open attachments unless you verify. Send all suspicious email as an attachment to report.spam@nc.gov

Thanks Debby.

Kimberly- Just let me know when and where to come on Dix campus tomorrow, and I'll be there! Thanks again.

-Daniel

Daniel Baum
Troutman Sanders
919-649-5444

From: Brutsman, Debra G <BrutsmanD@AETNA.com>

Sent: Wednesday, February 6, 2019 4:12 PM

To: 'Kimberley.Kilpatrick@dhhs.nc.gov' <Kimberley.Kilpatrick@dhhs.nc.gov>

Cc: Daniel Baum <Daniel.Baum@troutman.com>; Jones, Arif J <JonesA12@aetna.com>; Markovich, Scott R <MarkovichS@aetna.com>

Subject: RFP #30-190029-DHB Prepaid Health Plans

Importance: High

H Kimberly,

Thank you for taking my call regarding the document request for RFP #30-190029-DHB Prepaid Health Plans.

Daniel Baum will be picking up the jump drive tomorrow (Thursday) at 1:00 pm EST. I've cc'd him on this email in case you have further instructions.

Thanks again,

Debby Brutsman
Manager
Strategic Initiatives

M: 602-290-5186
E: brutsmand@aetna.com
<image001.png>

This e-mail may contain confidential or privileged information. If you think you have received this e-mail in error, please advise the sender by reply e-mail and then delete this e-mail immediately. Thank you. Aetna

This e-mail message (and any attachments) from Troutman Sanders LLP may contain legally privileged and confidential information solely for the use of the intended recipient. If you received this message in error, please delete the message and notify the sender. Any unauthorized reading, distribution, copying, or other use of this message (and attachments) is strictly prohibited.

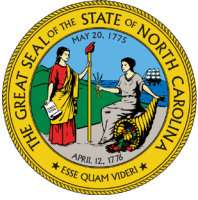
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NCDHHS-0062850

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Exhibit C



NC DEPARTMENT OF
**HEALTH AND
HUMAN SERVICES**
Division of Health Benefits

ROY COOPER • Governor

MANDY COHEN, MD, MPH • Secretary

DAVE RICHARD • Deputy Secretary, NC Medicaid

February 7, 2019

You have requested copies of the materials associated with RFP #30-190029-DHB Prepaid Health Plans. You are being provided the files listed below.

1. A copy of the RFP and Addenda as issued on the State's Interactive Purchasing System website.
2. A copy of the Revised and Restated RFP that incorporates revisions stated within Addenda and other requirements developed or modified during the evaluation process.
3. A redacted copy of each Offeror's response with clarifications, negotiation documents, or other materials supporting the response for:
 - a. Aetna Better Health of North Carolina, Inc., dba Aetna Better Health of North Carolina;
 - b. AmeriHealth Caritas North Carolina, Inc.;
 - c. Blue Cross and Blue Shield of North Carolina;
 - d. Carolina Complete Health, Inc.;
 - e. North Carolina Provider Owned Plans, Inc., dba My Health Providers
 - f. Optima Family Care of North Carolina, Inc.;
 - g. UnitedHealthcare of North Carolina, Inc.; and
 - h. WellCare of North Carolina, Inc.
4. A copy of the materials used during the evaluation process.
5. A copy of the Award Recommendation materials.
6. A copy of the Contract Approval Forms for the awarded Contracts.
7. A copy of the Contract Execution Pages for the awarded Contracts.
8. A copy of the Medicaid Facts sheet provided after the announcement of the awarded Contracts.

These files are provided to you as required under Section § 132-6 of the North Carolina Public Records Law. NC Medicaid – Division of Health Benefits is not responsible for any alterations or modifications made to these files once you receive.

If you have questions or issues opening the files, contact Kimberley Kilpatrick at Kimberley.Kilpatrick@dhhs.nc.gov or 919-527-7015.

Thank you for your interest and support of North Carolina's Medicaid Program as we transition to Managed Care.

NC MEDICAID

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES • DIVISION OF HEALTH BENEFITS

LOCATION: 820 South Boylan Avenue, McBryde Building, Raleigh NC 27603

MAILING ADDRESS: 1950 Mail Service Center, Raleigh NC 27699-1950

www.ncdhhs.gov • TEL: 919-527-7000 • FAX: 919-832-0225

AN EQUAL OPPORTUNITY / AFFIRMATIVE ACTION EMPLOYER

Exhibit D

Attachment #4 PHP Evaluation Committee Meeting Notes and Timeline

October 17, 2018, 10:00 AM – 12:00 PM

Kick Off Meeting for Evaluation Committee.

Attendees and Roles:

Scoring Members:	Non-Scoring Contract Leads	Non-Scoring Subject Matter Expert (SME)	Non-Scoring Legal Counsel	Non-Scoring Leadership
Tabitha Bryant Melanie Bush Patrick Doyle Sabrena Lea Catherine Pace Sheila Platts Amanda Van Vleet	Kimberly Kilpatrick Gregory Sligh	Sarah Gregosky	Lotta Crabtree	Jay Ludlam Mona Moon

1. See *Attachment #3 PHP Evaluation Kick-Off Meeting – Scoring Members* for the meeting presentation.
2. The Contract Leads conducted the Kick-Off Meeting. Items discussed included:
 - a. Ensuring and maintaining the integrity of the procurement process.
 - b. Confidentiality and Conflict of Interest Statements (Statements).
 - c. Location and process to access evaluation materials on SharePoint upon completion of the Statements.
 - d. Hardcopies of proposals also available in evaluation meeting room but must not leave the McBryde building
 - e. Evaluation ground rules.
 - f. Time commitment.
 - g. Notetaking. The attendees were advised that notes, if any, will be taken up during the evaluation and become part of the solicitation file.
 - h. Consensus scoring will be used. The Scoring Members will review and discuss the responses, determine if they need guidance from a SME or a Clarification to any Offeror's response, and work to reach consensus on the final score for each evaluation question.
 - i. Blocks of time will be scheduled, and specific sections to be discussed and scored will be communicated in advance of each meeting.
 - j. SMEs to be notified and scheduled in advance of scoring specific sections to provide any information requested prior to scoring a section.
 - k. Discussed the 5 Level Rating Scale Definitions. The baseline for scoring, where applicable, is that each response Meets Expectations. If the Committee

determines the response reflects something different, information supporting the rationale for assigning a different score will be documented. Discussed that some questions will have other criteria to score based on the type of question and information to be provided.

- I. The Evaluation Committee was taken to McBryde West Room 106 where the evaluation will be conducted.
3. Upon completion of the Confidentiality and Conflict of Interest Statements, Committee members were provided access to the *RFP 30-190029-DHB PHP Eval* folder on SharePoint.

October 23 and October 24, 2018

Kick-Off Meetings for Subject Matter Experts were held on October 23, 2018 2:00 – 3:00 PM and October 24, 10:00 – 11:00 AM.

1. See *Attachment #5 PHP Evaluation Kick-Off Meeting – SMEs* for the meeting presentation.
2. The Contract Leads conducted the Kick-Off Meeting. Items discussed included:
 - a. Initial SMEs identified for specific evaluation areas; others may be added.
 - b. Ensuring and maintaining the integrity of the procurement process.
 - c. Confidentiality and Conflict of Interest Statements (Statements).
 - d. Location and process to access evaluation materials on SharePoint upon completion of the Statements.
 - e. Hardcopies of proposals will be made available upon request but must not leave the McBryde building.
 - f. Time commitment and being prepared to support the Evaluation Committee.
 - g. Notetaking. The attendees were advised that notes, if any, will be taken up during the evaluation and become part of the Contract File.
 - h. SMEs to be notified and scheduled in advance of scoring specific sections to provide any information requested prior to scoring a section. The anticipated schedule for Evaluation Areas was provided for planning purposes and notes as subject to change.
 - i. Importance of SMEs reviewing both the RFP as posted/revised and the specific sections of Offeror responses.
 - j. Explained scoring methods. Advised SMEs that they will not be scoring but presenting information on particular areas/sections of the RFP and answering specific questions for the Evaluation Committee to use in scoring.
3. Since some SMEs were unable to attend the sessions on October 23 and October 24, 2018, the Contract Leads worked with SMEs as needed for individual SME Kick-Off Meetings which were scheduled on-demand.

4. Upon completion of the Confidentiality and Conflict of Interest Statements, SMEs were provided access to the *RFP 30-190029-DHB PHP Eval* folder on SharePoint.
5. For a list of all SMEs that participated in the evaluation process, see *Attachment #6 PHP Evaluation SME List*.

October 24, 2018

Evaluation Committee Meeting

Attendees: Melanie Bush, Catherine Pace, Tabitha Bryant, Sabrena Lea, Patrick Doyle, Sheila Platts, Amanda Van Vleet, Kimberley Kilpatrick, Gregory Sligh and SME Sarah Gregosky (attended briefly).

1. Posed the Confidentiality and Conflict of Interest question to the Committee – no conflicts
2. Scored Section VIII., First Restated and Revised Attachment O. Offeror's Proposal and Response, 1. Minimum Qualifications for Aetna Better Health of North Carolina, Inc (Aetna), AmeriHealth Caritas of North Carolina, Inc (AmeriHealth), Blue Cross and Blue Shield of North Carolina Healthy Blue (BCBS), Carolina Complete Health, Inc (CCH), North Carolina Provider Owned Plans, Inc dba My Health by Health Providers (My Health), Optima Family Care of North Carolina (Optima), United HealthCare of North Carolina, Inc (United) and WellCare of North Carolina, Inc (WellCare).
3. The Committee determined all Offerors met the Minimum Qualifications.

October 25, 2018

Evaluation Committee Meeting

Attendees: Sabrena Lea, Patrick Doyle, Tabitha Bryant, Melanie Bush, Catherine Pace, Sheila Platts, Amanda Van Vleet, Kimberley Kilpatrick, Gregory Sligh, and Legal Counsel Lotta Crabtree (attended briefly).

1. Posed the Confidentiality and Conflict of Interest question to the Committee – no conflicts
2. Sarah Gregosky presented information to frame and provide context of the RFP and answer any questions of the Evaluation Committee prior to scoring.
3. Began scoring Offeror Qualifications/Experience for Aetna, AmeriHealth, BCBS, CCH and My Health.
4. The Committee decided to put questions 3, 5, 7, 8, 9 and 10 on hold pending consultation with Lotta Crabtree on scoring criteria. The Committee did not think the scoring criteria/rating definitions fit the questions making it difficult to evaluate.

October 26, 2018

Evaluation Committee Meeting

Attendees: Amanda Van Vleet, Sabrena Lea, Sheila Platts, Patrick Doyle, Tabitha Bryant, Melanie Bush, Catherine Pace, Kimberley Kilpatrick, Gregory Sligh, and Legal Counsel Lotta Crabtree (attended briefly).

1. Posed the Confidentiality and Conflict of Interest question to the Committee – no conflicts
2. Completed scoring Section VIII., First Restated and Revised Attachment O. Offeror's Proposal and Response. 3. Offeror Qualifications/Experience for Optima, United and WellCare but for questions previously tabled.
3. The Committee voiced its concerns to Legal Counsel that the scoring criteria/rating definitions for questions 3, 7, 8, 9, and 10 did not fit the questions making it difficult to evaluate. Lotta Crabtree will review all scoring criteria/rating definitions for the remaining questions and make recommendations regarding criteria/rating definitions based on that review.
4. The Committee proceeded with scoring question 5 for Aetna, AmeriHealth, BCBS, CCH, My Health, Optima and WellCare.

October 30, 2018

Evaluation Committee Meeting

Attendees: Catherine Pace, Melanie Bush, Sheila Platts, Amanda Van Vleet, Tabitha Bryant, Patrick Doyle, Sabrena Lea, Kimberley Kilpatrick and Gregory Sligh.

1. Posed the Confidentiality and Conflict of Interest question to the Committee – no conflicts.
2. Based on consultation with Lotta Crabtree and SMEs modifications to scoring criteria for questions 7, 8, 9, 10 and 15 were made because the Evaluation 5 Level Rating Scale was not appropriate for the questions. The modifications did not change the weight or value of the possible points available, only the criteria/rating definitions.
3. In addition, Lotta Crabtree requested the scoring criteria for questions 56, 57 and 59 be reviewed by the SMEs for this area. Based on SME feedback, modifications were made to the criteria/rating definitions but the weight or value of possible points available did not change.
4. Scoring was completed for questions 3, 7, 8, 9 and 10 for Offerors.
5. Began scoring Section VIII., Scope of Services, Administration and Management, questions 12-19 for Aetna, AmeriHealth and BCBS.

October 31, 2018

Evaluation Committee Meeting

Attendees: Sabrena Lea, Patrick Doyle, Tabitha Bryant, Melanie Bush, Catherine Pace, Sheila Platts
Amanda Van Vleet, Kimberley Kilpatrick and Gregory Sligh.

1. Posed the Confidentiality and Conflict of Interest question to the Committee – no conflicts
2. Completed scoring Section VIII., Scope of Services, Administration and Management, questions 12-19 for CCH, My Health, Optima, United and WellCare.

November 1, 2018

Evaluation Committee Meeting

Attendees: Catherine Pace, Melanie Bush, Sheila Platts, Amanda Van Vleet, Tabitha Bryant, Patrick Doyle, Sabrena Lea, Kimberley Kilpatrick, Gregory Sligh and SME Sarah Gregosky (attended briefly).

1. Posed the Confidentiality and Conflict of Interest question to the Committee – no conflicts
2. Committee continued their discussion on question 19.
3. Sarah Gregosky provided details about question 20 which covered Section V.B. 1. Eligibility for Medicaid Managed Care and Section V.B.2. Medicaid Managed Care Enrollment and Disenrollment.
4. Continued scoring Section VIII., Scope of Services, Administration and Management, questions 12-19 for AmeriHealth and Aetna.

November 6, 2018

Evaluation Committee Meeting

Attendees: Catherine Pace, Melanie Bush, Amanda Van Vleet, Tabitha Bryant, Patrick Doyle, Sabrena Lea, SME Sharon McDougal, SME Lavette Brown, SME Debra Farrington, SME Sonja McLeod, Kimberley Kilpatrick, Gregory Sligh and Sheila Platts (joined later).

1. Posed the Confidentiality and Conflict of Interest question to the Committee – no conflicts
2. Sharon McDougal, Lavette Young, Debra Farrington and Sonya McLeod gave an overview of their review of each response and answered Committee questions for question 20 from Section V.B.1. Eligibility for Medicaid managed Care and Section V.B.2. Medicaid Managed Care Enrollment and Disenrollment.
3. Began scoring questions 20-24 from Section V.B.1. Eligibility for Medicaid Managed Care and Section V.B.1. Medicaid Managed Care Enrollment and Disenrollment for WellCare, United, Optima and My Health.

November 7, 2018

Evaluation Committee Meeting

Attendees: Catherine Pace, Melanie Bush, Amanda Van Vleet, Tabitha Bryant, Patrick Doyle, Sabrena Lea, Kimberley Kilpatrick and Gregory Sligh.

1. Posed the Confidentiality and Conflict of Interest question to the Committee – no conflicts
2. Continued scoring questions 20-24, Section V.B.1. Eligibility for Medicaid managed Care and Section V.B.2. Medicaid Managed Care Enrollment and Disenrollment for CCH, BCBS, AmeriHealth and Aetna.

Note: Secretary Cohen and Amanda Parks made a brief visit to thank the Committee for their work and for being a part of the process. Secretary Cohen was not involved in any discussions of the responses or scoring process, nor were any Offeror responses shared.

November 13, 2018

Evaluation Committee Meeting

Attendees: Catherine Pace, Melanie Bush, Tabitha Bryant, Patrick Doyle, Kimberley Kilpatrick, Gregory Sligh, Amanda Van Vleet and SME Dr. Nancy Henley (attended briefly via call in until she arrived).

1. Posed the Confidentiality and Conflict of Interest question to the Committee – no conflicts.
2. Began scoring questions 25-31 from the Benefits and Care Management section for Aetna and AmeriHealth.
3. Committee decided to delay scoring question 29 until SME John Stancil could attend.
4. Dr. Nancy Henley reviewed each response and answered Committee questions for this section.

November 14, 2018

Evaluation Committee Meeting

Attendees: Catherine Pace, Melanie Bush, Tabitha Bryant, Patrick Doyle, Sheila Platts, Sabrena Lea, Kimberley Kilpatrick, Gregory Sligh, Amanda Van Vleet, SME Kelsi Knick (attended briefly) and Leadership Mona Moon (attended briefly).

1. Posed the Confidentiality and Conflict of Interest question to the Committee – no conflicts.
2. Continued scoring questions 25-31 minus question 29 from the Benefits and Care Management section for BCBS.
3. Kelsi Knick joined to provide comments and answer Committee questions for Benefits and Care Management.

4. Question 25 for BCBS was not scored after discussion with Kelsi Knick as to whether the LME/MCOs will be providing care coordination for Behavioral Health services for BCBS's PHP. The Committee discussed requesting a clarification pending a consultation with Sarah Gregosky, Kelsi Knick and Lotta Crabtree.

November 15, 2018

Evaluation Committee Meeting

Attendees: Catherine Pace, Melanie Bush, Sheila Platts, Amanda Van Vleet, Tabitha Bryant, Patrick Doyle, Sabrena Lea, SME Dr. Nancy Henley (attended briefly), SME John Stancil (attended briefly), Kimberley Kilpatrick and Gregory Sligh.

1. Posed the Confidentiality and Conflict of Interest question to the Committee – no conflicts.
2. John Stancil provided assessment of question 29 in the Benefits and Care Management section.
3. Dr. Nancy Henley provided overall assessment, general comments and answered any Committee questions for Care Management.
4. Committee resumed scoring questions 25-31 minus question 29 from the Benefits and Care Management section for CCH, My Health, Optima and United.

November 16, 2018

Evaluation Committee Meeting

Attendees: Catherine Pace, Melanie Bush, Amanda Van Vleet, Tabitha Bryant, Patrick Doyle, Sabrena Lea, Kimberley Kilpatrick, Gregory Sligh and SME Sarah Gregosky (attended briefly).

1. Posed the Confidentiality and Conflict of Interest question to the Committee – no conflicts.
2. Committee resumed scoring for question 29 from the Benefits and Care Management section for WellCare, United and Optima.
3. Sarah Gregosky provided details concerning questions 55 and 56 for the Claims and Encounter Management section.

November 19, 2018

Attendees: Catherine Pace, Melanie Bush, Sheila Platts, Amanda Van Vleet, Tabitha Bryant, Patrick Doyle, Sabrena Lea, Kimberley Kilpatrick, Gregory Sligh, SME Cheryl McQueen (attended briefly), SME Adolph Simmons (attended briefly), SME Kelsi Knick (attended briefly), Legal Counsel Lotta Crabtree (attended briefly), SME Sarah Gregosky (attended briefly) and SME Dr. Nancy Henley (attended briefly).

1. Posed the Confidentiality and Conflict of Interest question to the Committee – no conflicts.

2. Cheryl McQueen and Adolph Simmons provided details concerning questions 56 from the Claims and Encounter Management section.
3. Dr. Nancy Henley returned and completed her comments for Care Management.
4. Committee began scoring questions 56 from the Claims and Encounter Management section for My Health, Optima, United, WellCare, Aetna, AmeriHealth and BCBS.
5. Kelsi Knick, Sarah Gregosky and Lotta Crabtree attended to discuss the need for a clarification from BCBS regarding its response to 25. It was determined a clarification was needed.
6. BCBS Clarification #1 issued. See *Table 2 – Offeror Clarifications*.

November 20, 2018

Evaluation Committee Meeting

Attendees: Catherine Pace, Melanie Bush, Sheila Platts, Amanda Van Vleet, Tabitha Bryant, Patrick Doyle, Sabrena Lea, SME Adolph Simmons (attended briefly), Kimberley Kilpatrick and Gregory Sligh.

1. Posed the Confidentiality and Conflict of Interest question to the Committee – no conflicts.
2. Committee continued scoring question 56 from the Claims and Encounter Management section for CCH.
3. Adolph Simmons responded to additional questions from the Committee concerning question 56.

November 26, 2018

Evaluation Committee Meeting

Attendees: Catherine Pace, Sheila Platts, Tabitha Bryant, Melanie Bush, Patrick Doyle, Sabrena Lea, Kimberley Kilpatrick and Gregory Sligh.

1. Posed the Confidentiality and Conflict of Interest question to the Committee – no conflicts.
2. Committee scored question 55 from the Claims and Encounter Management section for My Health, Optima, United, WellCare, Aetna, AmeriHealth, BCBS and CCH.
3. BCBS Clarification #1 reviewed with Committee and determined to have clarified the concern. Completed scoring question 25 for BCBS.

November 27, 2018

Evaluation Committee Meeting

Attendees: Catherine Pace, Sheila Platts, Tabitha Bryant, Melanie Bush, Patrick Doyle, Sabrena Lea, SME Jean Holliday (attended briefly), Kimberley Kilpatrick and Gregory Sligh.

1. Posed the Confidentiality and Conflict of Interest question to the Committee – no conflicts.
2. Committee scored question 55 from the Claims and Encounter Management section for My Health, Optima, United, WellCare, Aetna, AmeriHealth, BCBS and CCH.
3. Jean Holliday gave comments on question 55 from the Claims and Encounter Management section. She also indicated the need to issue Clarifications to CCH and United for review of question 11 regarding commitment to offer Qualified Health Plans (QHPs) in NC. Clarifications to be drafted and issued. See *Table 2 – Offeror Clarifications* for additional information.

Contracting Team Note: Offeror Client References were emailed November 27, 2018. Kimberley Kilpatrick emailed each reference contact and included the Client Reference Survey Template for each request. See *Attachment #8 Offeror Client Reference Questionnaire Template*. Responses for Client References were scored as received by the Committee. *Table 1 – Offeror Client Reference Check Tracking* documents the requests and follow up activities to obtain all Offeror references.

November 28, 2018

Evaluation Committee Meeting

Attendees: Catherine Pace, Melanie Bush, Sheila Platts, Tabitha Bryant, Patrick Doyle, Sabrena Lea (by phone), SME Kelly Crosbie (attended briefly), SME Dr. Nancy Henley (attended briefly), SME Kelsi Knick (attended briefly), SME Erica Ferguson (attended briefly by phone), SME Beth Lovett (attended briefly by phone), Legal Counsel Lotta Crabtree (attend briefly), Kimberley Kilpatrick, Gregory Sligh and Leadership Mona Moon (attended briefly).

1. Posed the Confidentiality and Conflict of Interest question to the Committee – no conflicts.
2. Kelly Crosbie, Dr. Nancy Henley, Kelsi Knick, Erica Ferguson and Beth Lovett by phone, gave their comments and observations concerning questions 32 – 38 for the Benefits and Care Management section.
3. Committee began scoring question 32 – 38 for United.
4. Committee consulted with Lotta Crabtree regarding LME/MCO authority. Crabtree to research issue and follow up with Committee.

Note: Mona Moon attended 8:30 – 9:30 to discuss the evaluation schedule with the Evaluation Committee, including the areas remaining and suggestions for completing the evaluation within the scheduled timeframe.

November 29, 2018

Evaluation Committee Meeting

Attendees: Catherine Pace, Melanie Bush, Sheila Platts, Tabitha Bryant, Patrick Doyle, Sabrena Lea, Kimberley Kilpatrick, Gregory Sligh.

1. Posed the Confidentiality and Conflict of Interest question to the Committee – no conflicts.
2. Committee continued scoring question 32 – 38 for the Benefits and Care Management section for WellCare, Aetna, AmeriHealth and BCBS.

Note: CCH Clarification #1 issued 11/29/2018. The United Clarification #1 issued 11/29/2018. Clarifications would be discussed with question #11. See *Table 2 – Offeror Clarifications* for additional information.

November 30, 2018

Evaluation Committee Meeting

Attendees: Melanie Bush, Sheila Platts, Amanda Van Vleet, Tabitha Bryant, Patrick Doyle, SME Sarah Gregosky (attended briefly), SME Kelsi Knick (by phone), Kimberley Kilpatrick and Gregory Sligh.

1. Posed the Confidentiality and Conflict of Interest question to the Committee – no conflicts.
2. Committee continued scoring question 32 – 38 for the Benefits and Care Management section for CCH, My Health and Optima.
3. Kelsi Knick called in to answer questions concerning Benefits and Care Management.
4. Sarah Gregosky explained the Stakeholders Engagement section, questions 47-49.

Note: CCH Clarification #1 was returned 11/30/2018. United Clarification #1 was returned 11/30/2018. Clarifications would be reviewed when the Committee reconvened to discuss question 11 commitment to offer QHPs. See *Table 2 – Offeror Clarifications* for additional information.

December 3, 2018

Evaluation Committee Meeting

Attendees: Melanie Bush, Sheila Platts, Tabitha Bryant, Patrick Doyle, Amanda Van Vleet (by phone), Sabrena Lea (by phone), Legal Counsel Lotta Crabtree (attended briefly), Kimberley Kilpatrick and Gregory Sligh.

1. Posed the Confidentiality and Conflict of Interest question to the Committee – no conflicts.
2. Lotta Crabtree addressed the Committee's question regarding the LME/MCOs ability to contract with the PHPs. The question was a general question by the Committee and not for clarifying or scoring a particular response.

December 4, 2018

Evaluation Committee Meeting

Attendees: Cathy Pace, Melanie Bush, Amanda Van Vleet, Tabitha Bryant, Patrick Doyle, Sabrena Lee, Sheila Platts, Kimberley Kilpatrick and Gregory Sligh.

1. Posed the Confidentiality and Conflict of Interest question to the Committee – no conflicts.
2. Committee began scoring questions 47-49 for the Stakeholder Engagement section.

December 5, 2018

Evaluation Committee Meeting

Attendees: Cathy Pace, Melanie Bush, Sheila Platts, Tabitha Bryant, Patrick Doyle, Sabrena Lee, Amanda Van Vleet, SME Debra Farrington (attended briefly), SME Lynne Teste (attended briefly), SME Sharon McDougal (attended briefly), Kimberley Kilpatrick and Gregory Sligh.

1. Posed the Confidentiality and Conflict of Interest question to the Committee – no conflicts.
2. Debra Farrington Lynn Testa and Sharon McDougal talked to the Committee about Stakeholder Engagement questions 47-49.
3. Committee completed scoring for question 47-49.

December 6, 2018

Evaluation Committee Meeting

Attendees: Cathy Pace, Sheila Platts, Amanda Van Vleet, Tabitha Bryant, Patrick Doyle, Sabrena Lee, Kimberley Kilpatrick and Gregory Sligh.

1. Posed the Confidentiality and Conflict of Interest question to the Committee – no conflicts.
2. Committee began scoring the Compliance section, questions 60-63 for Optima, CCH, My Health, United, WellCare and BCBS.

December 7, 2018

Evaluation Committee Meeting

Attendees: Cathy Pace, Sheila Platts, Amanda Van Vleet, Tabitha Bryant, Patrick Doyle, Sabrena Lee (by phone), SME Sarah Gregosky (attended briefly), Kimberley Kilpatrick and Gregory Sligh.

1. Posed the Confidentiality and Conflict of Interest question to the Committee – no conflicts.
2. Committee completed scoring questions 60-63 for Aetna and AmeriHealth.

3. Sarah Gregosky explained the various parts of the Program Operations questions.

December 12, 2018

Evaluation Committee Meeting

Attendees: Cathy Pace, Melanie Bush, Amanda Van Vleet, Tabitha Bryant, Patrick Doyle, SME Janice Norris (attended briefly), SME Sarah Gregosky (attended briefly), Kimberley Kilpatrick and Gregory Sligh.

1. Posed the Confidentiality and Conflict of Interest question to the Committee – no conflicts
2. Janice Norris and Sarah Gregosky provided an overview of the responses and answered the Committee's questions on the Programs Operations section.
3. The Committee began scoring questions 50-54 of the Program Operations section for Aetna, AmeriHealth, BCBS, CCH, My Health and Optima.

December 13, 2018

Evaluation Committee Meeting

Attendees: Cathy Pace, Melanie Bush, Sheila Platts, Tabitha Bryant, Patrick Doyle, Amanda Van Vleet, Sabrena Lea, SME Cheryl McQueen (attended briefly), SME Jase Slaughter (attended briefly), SME Pyreddy Reddy (attended briefly), SME Steve Tedder (attended briefly), SME Angela Taylor (attended briefly), SME Rajeev Kotrannavar (initially by phone, attended briefly), Gregory Sligh and Kimberley Kilpatrick (called in briefly).

1. Posed the Confidentiality and Conflict of Interest question to the Committee – no conflicts.
2. Cheryl McQueen, Jase Slaughter, Pyreddy Reddy, Steve Tedder, Angela Taylor provided an overview of the responses and answered the Committee's question for questions 64 and 65.
3. The Committee completed scoring questions 50-54 of the Program Operations section for United and WellCare.
4. The Committee began and completed scoring questions 64 and 65 for Aetna, AmeriHealth, BCBS, CCH, My Health Care, Optima, United and WellCare.

December 15, 2018

Contracting Team Activities: Follow up emails were sent to Offeror references regarding outstanding questionnaires. See *Table 1 – Offeror Client Reference Check Tracking*.

December 17, 2018

Evaluation Committee Meeting

Attendees: Cathy Pace, Patrick Doyle, Sheila Platts, Sabrena Lea, Amanda Van Vleet, Melanie Bush, Tabitha Bryant, SME Deirdre Brown (attended briefly), SME Alfred Greco (attended briefly), SME Jean Holliday (attended briefly), SME Julia Lerche (attended briefly), Kimberley Kilpatrick and Gregory Sligh.

1. Posed the Confidentiality and Conflict of Interest question to the Committee – no conflicts.
2. Deirdre Brown, Alfred Greco, Jean Holliday and Julia Lerche provided an overview of the responses and answered the Committee's questions on the Financial Requirements section for questions 57 – 59.
3. The Committee began and completed scoring questions 57-59 of the Financial Requirements section for Aetna, AmeriHealth, BCBS, CCH, My Health, Optima, United and WellCare.
4. The Committee decided to not score question 59.a. for BCBS until a clarification was obtained and Committee could consult with SME Jean Holliday.

December 18, 2018

Evaluation Committee Meeting

Attendees: Cathy Pace, Patrick Doyle, Sheila Platts, Melanie Bush, Sabrena Lea, Tabitha Bryant, Amanda Van Vleet, SME John Thompson (attended briefly), SME Sarah Gregosky (attended briefly), Kimberley Kilpatrick and Gregory Sligh.

1. Posed the Confidentiality and Conflict of Interest question to the Committee – no conflicts.
2. John Thompson provided an overview of the responses and answered the Committee's questions on the Compliance section for questions 60 – 63.
3. The Committee began scoring Offeror's Client References for Aetna ([REDACTED]), AmeriHealth (Delaware, Michigan), BCBS (Maryland, South Carolina), CCH (New Hampshire, Kansas, Superior HealthPlan, Inc. of Texas), My Health ([REDACTED]), Optima (Huntsville Hospital Health System, Virginia Division of Medical Services – Operations, Virginia Division of Medical Services – Integrated Care), United (Michigan Department of Health and Human Services, Rhode Island Department of Health and Human Services, Kansas KDHE) and WellCare (Staywell Health Plan of Florida).
4. The Committee asked to consult with Lotta Crabtree concerning BCBS's use of BlueChoice Health Plan of South Carolina as a reference and Optima's use of Huntsville Hospital Health System. Pending on the consultation the references were not scored.
5. Sarah Gregosky gave an overview of Use Case Scenarios.

Contracting Team Note: Kimberley Kilpatrick called Lotta Crabtree and posed the questions from the Committee on the two references in Item #4 above. Advised the Committee to be consistent in determining if the reference was a client reference and relevant to the scope of services.

December 19, 2018

Evaluation Committee Meeting

Attendees: Cathy Pace, Melanie Bush, Sheila Platts, Tabitha Bryant Patrick Doyle, Sabrena Lea, SME Jean Holliday (attended briefly), Amanda Van Vleet, Kimberley Kilpatrick and Gregory Sligh.

1. Posed the Confidentiality and Conflict of Interest question to the Committee – no conflicts.
2. Jean Holliday explained question 11, commitment to offer QHPs, scoring. Reviewed the information obtained as part of CCH Clarification #1 and United Clarification #1. Committee scored question 11 based on the information provided by Jean Holliday. See *Attachment #9 Question 11 Data* and *Attachment #10 Question 11 NC County Exchange Enrollment* for information on how the points were calculated and responses scored
3. The Committee scored a reference for Aetna ([REDACTED]).
4. Legal Counsel Lotta Crabtree advised the Committee to be consistent in their consideration, treatment and scoring of references. Based on the consultation for the BCBS and Optima references on December 18 for Item #4, the consensus was to not score the references as the BCBS reference was deemed not a “client reference” and services were never implemented for the Optima reference.

SME Activity Note: Prior to meeting with the Committee to review question 11, quality assurance and verification of the data and formulas were conducted by SMEs Jean Holliday and Sarah Gregosky.

December 20, 2018

Contract Team Note: BCBS Clarification #2 to confirm Financial Management question 56 issued 12/20/2018 and returned 12/20/2018. SME Jean Holliday reviewed and confirmed it provided the necessary information. Jean will share with Committee upon return in January 2019. See *Table 2 – Offeror Clarifications* for additional information.

January 2, 2019

Evaluation Committee Meeting

Attendees: Sheila Platts, Cathy Pace, Patrick Doyle, Amanda Van Vleet, Melanie Bush, Sabrena Lea, SME Reginald Little (attended briefly), SME Lynne Testa (attended briefly), SME Julia Lerche (attended briefly), SME Jean Holliday (attended briefly), Kimberley Kilpatrick and Gregory Sligh.

1. Posed the Confidentiality and Conflict of Interest question to the Committee – no conflicts.

2. Reginald Little, Lynne Testa, Julia Lerche and Jean Holliday provided an overview of the responses and answered the Committee's questions on the Providers section, questions 40-44.
3. Information on BCBS Clarification #2 shared and the Committee determined that it did not impact scoring for BCBS question 56.
4. The Committee began and completed scoring question 43 of the Providers section for Aetna, AmeriHealth, BCBS, CCH, My Health, Optima, United and WellCare.
5. The Committee started scoring the remaining questions, 40, 41, 42 and 44 of the Providers section for Aetna, AmeriHealth BCBS and CCH.

January 3, 2019

Evaluation Committee Meeting

Attendees: Sheila Platts, Cathy Pace, Melanie Bush, Patrick Doyle, Amanda Van Vleet, SME Jean Holliday (by phone), Kimberley Kilpatrick and Gregory Sligh.

1. Posed the Confidentiality and Conflict of Interest question to the Committee – no conflicts.
2. Jean Holliday called in to clarify the Committee's question on Evergreen contracts.
3. The Committee resumed scoring the Providers section, questions 40, 41, 42, and 44 for My Health, Optima, United and WellCare.
4. Client References were scored for AmeriHealth Caritas (Louisiana department of Health) and Carolina Complete Health (Managed Health Services, Inc. "MHS").

January 7, 2019

Evaluation Committee Meeting

Attendees: Sheila Platts, Cathy Pace, Amanda Van Vleet, Tabitha Bryant, Melanie Bush, SME Terri Pennington (attended briefly), SME Jaimica Wilkins (attended briefly), SME Kelly Crosbie (attended briefly), Kimberley Kilpatrick and Gregory Sligh.

1. Posed the Confidentiality and Conflict of Interest question to the Committee – no conflicts.
2. Terri Pennington, Jaimica Wilkins and Kelly Crosbie presented their findings on question 45 and 46 for Quality and Value in Section V.E.1. Quality Management and Quality Improvement.
3. The Committee began and completed Quality and Value, questions 45 and 46 for Aetna, AmeriHealth, BCBS, CCH, My Health, Optima, United and WellCare.
4. Shared that Negotiation Document #1 would be sent to all Offerors to incorporate revisions necessary to the RFP based on factors such as CMS waiver approval. The Offerors were to accept the revisions and return. A copy of the Negotiation Document was placed on SharePoint for the Committee to review.

Contracting Process Note: The Contracting Leads reviewed a list of items in the Offerors' responses that were noted by the Committee as potential conflicts or technical issues with regards to RFP requirements to determine if clarifications were necessary. The Contracting Leads would discuss the list with Legal Counsel and appropriate SMEs and issue clarifications as needed.

January 8, 2019

Evaluation Committee Meeting

Attendees: Sheila Platts, Cathy Pace, Amanda Van Vleet, Melanie Bush, Sabrena Lea, Tabitha Bryant, SME Jean Holliday (attended briefly), SME Dr. Nancy Henley (attended briefly), Lotta Crabtree (by phone), Kimberley Kilpatrick and Gregory Sligh.

1. Posed the Confidentiality and Conflict of Interest question to the Committee – no conflicts.
2. Jean Holliday presented BCBS Clarification #2 for quota share agreement as a part of BCBS's response for question 59 of the Financial Requirements section.
3. The Committee scored question 59.a. for BCBS after receiving the clarification.
4. The Committee scored the Offeror's Client References section for Aetna ([REDACTED]), AmeriHealth Caritas (South Carolina Department of Health and human services) and WellCare (WellCare of New Jersey, Inc.).
5. Dr. Nancy Henley provided an overview of the responses and answered the Committee's questions on Use Case Scenarios 1-5 for Aetna, AmeriHealth, BCBS, CCH, My Health, Optima, United and WellCare.
6. Consulted Lotta Crabtree by phone regarding scoring criteria for Use Case Scenarios.
7. Scoring completed for Use Case Scenario 1 for Aetna, AmeriHealth, BCBS, CCH, My Health, Optima and United.
8. Negotiation Document #1 issued to all Offerors. See *Table 3 – Offeror Negotiation Documents*.

January 9, 2019

Evaluation Committee Meeting

Attendees: Tabitha Bryant, Sheila Platts, Cathy Pace, Patrick Doyle, Melanie Bush, Amanda Van Vleet, SME Dr. Dr. Nancy Henley (attended briefly), Sabrena Lea (by phone), Kimberley Kilpatrick and Gregory Sligh.

1. Posed the Confidentiality and Conflict of Interest question to the Committee – no conflicts.
2. The Committee continued scoring Use Case Scenarios 1 for WellCare and Use Case Scenarios 2, 3, 4, 5 and 7 for Aetna, AmeriHealth, BCBS, CCH, My Health, Optima, United and WellCare.

3. Dr. Nancy Henley was consulted regarding CCH/Centene's plan with Community Care Networks and My Health's with Presbyterian Hospital in responses to the Use Case scenarios.

January 10, 2019

Evaluation Committee Meeting

Attendees: Sabrena Lea, Melanie Bush, Tabitha Bryant, Cathy Pace, Amanda Van Vleet, Patrick Doyle, Kimberley Kilpatrick and Gregory Sligh.

1. Posed the Confidentiality and Conflict of Interest question to the Committee – no conflicts.
2. The Committee scored Use Case Scenario 6 for Aetna, AmeriHealth, BCBS, CCH, My Health, United and WellCare.

January 11, 2019

Attendees: Sheila Platts, Melanie Bush, Tabitha Bryant, Cathy Pace, Amanda Van Vleet, Patrick Doyle, Sabrena Lea, SME Kelly Crosbie (attended briefly), SME Kelsi Knick (attended briefly), Kimberley Kilpatrick and Gregory Sligh.

1. Posed the Confidentiality and Conflict of Interest question to the Committee – no conflicts.
2. Kelly Crosbie and Kelsi Knick answered questions concerning what role LME/MCOs may assume with Care Management.
3. Based on a review by the Contracting Team (see January 7, Contracting Process Note), clarifications would be issued to the following Offeror's for confirmation of adherence to RFP requirements:
 - a. Aetna Clarification #1
 - b. AmeriHealth Clarification #1
 - c. CCH Clarification #2
 - d. Optima Clarification #1.

These Clarifications were issued January 13, 2019. See *Table 2 – Offeror Clarifications* for additional information.

January 14, 2019

Evaluation Committee Meeting

Attendees: Sheila Platts, Melanie Bush, Tabitha Bryant, Cathy Pace, Amanda Van Vleet, Sabrena Lea, Kimberley Kilpatrick, Patrick Doyle (by phone) and Gregory Sligh (by phone).

1. Posed the Confidentiality and Conflict of Interest question to the Committee – no conflicts.

2. The Committee agreed to meet the following day to review the scores to confirm the documentation for scores of Partially Meets/Does Not Meet was clear, consistent across all Offerors and sufficiently detailed. See *Table 4 – Scoring Validation Partially Meets/Does Not Meet*. This exercise would be one of several quality assurance reviews to ensure consistency and accuracy of the score.
3. Confirmed all Negotiation Documents #1 had been properly executed and returned by each Offeror.

January 15, 2019

Evaluation Committee Meeting

Attendees: Sheila Platts, Melanie Bush, Tabitha Bryant, Cathy Pace, Amanda Van Vleet, Sabrena Lea, Patrick Doyle, Gregory Sligh and Kimberley Kilpatrick.

1. Posed the Confidentiality and Conflict of Interest question to the Committee – no conflicts.
2. The Committee completed review of scores for Partially Meets/Does Not Meet to ensure the scores were clear, consistent across all Offerors and sufficiently detailed.

Contracting Team Note: As part of the quality assurance process, Mona Moon inquired about the status of outstanding references. Kimberley Kilpatrick noted the dates of requests and follow ups for references that were still outstanding. After discussing with Lotta Crabtree, the decision was made to send a final request for all outstanding Offeror Client References with a due date/time of January 17, 9:00 AM EST. Kimberley Kilpatrick issued the follow up requests January 16 by 9:30 AM for all outstanding references. Information for the dates of all reference requests and follow ups are documented in *Table 1 – Offeror Client Reference Check Tracking*.

January 16, 2019

9:00 AM Evaluation Committee Meeting

Attendees: Sheila Platts, Melanie Bush, Tabitha Bryant, Cathy Pace, Amanda Van Vleet, Sabrena Lea, Patrick Doyle, Leadership Mona Moon, SME Sarah Gregosky, Legal Counsel Lotta Crabtree, Kimberley Kilpatrick and Gregory Sligh.

1. Posed the Confidentiality and Conflict of Interest question to the Committee – no conflicts.
2. Mona Moon reviewed the remaining steps of the process leading up to the announcement of awards, including continued quality review activities of the scores to ensure consistency and accuracy.
3. Mona explained the process for the last request made for Offeror's outstanding client references which were due no later than January 17 by 9:00 AM EST.

Attachment #4 PHP Evaluation Committee Meeting Notes and Timeline

4. Aetna Clarification #1, AmeriHealth Clarification #1, CCH Clarification #2 and Optima Clarification #1 were reviewed and discussed with Mona Moon, Lotta Crabtree, Sarah Gregosky and the Committee. No scores were changed based on these Clarifications.
5. Discussion of the Clarifications in Item #4 above generated a discussion on the United response and role of the LME/MCOs.
6. Based on the discussion Lotta Crabtree will draft Clarification #2 for United concerning care management and LME/MCOs and bring back to the Committee for review at 3:30 PM.

3:00 PM Contract Team and SME Meeting

Attendees: Jim Bard, Brandon Brown, Mona Moon, Kimberley Kilpatrick and Gregory Sligh.

Excel SMEs James Bard and Brandon Brown checked the scoring spreadsheet to make sure formulas and links between worksheets were correct. All formatting errors were corrected. A few technical errors (i.e., incorrect cell reference in a formula) were discovered and corrected. These technical errors did not change or affect any scores. Brandon Brown confirmed the totals on each of the individual sheets matched the summary totals.

3:30 PM Evaluation Committee Meeting

Attendees: Sheila Platts, Melanie Bush, Tabitha Bryant, Cathy Pace, Amanda Van Vleet, Sabrena Lea, Patrick Doyle, Leadership Mona Moon, SME Sarah Gregosky, Legal Counsel Lotta Crabtree, SME Kelsi Knick, Kimberley Kilpatrick and Gregory Sligh.

Draft United Clarification #2 reviewed with the Committee. Clarification to be revised based on Committee feedback and will be presented to the Committee for review on January 17.

January 17, 2019

Evaluation Committee Meeting

Attendees: Sheila Platts, Melanie Bush, Tabitha Bryant, Cathy Pace, Amanda Van Vleet, Sabrena Lea, Patrick Doyle, Leadership Mona Moon, SME Sarah Gregosky (attended briefly), Legal Counsel Lotta Crabtree (attended briefly), SME Kelsi Knick (attended Briefly), Kimberley Kilpatrick and Gregory Sligh.

1. Posed the Confidentiality and Conflict of Interest question to the Committee – no conflicts.
2. Lotta Crabtree reviewed the draft United Clarification #2 with the Committee and Kelsi Knick who provided input and the draft was finalized.
3. The Clarification will be sent January 17 requesting the response returned no later than January 18 by 9:00 AM.
4. Client Reference scored for WellCare (WellCare of Kentucky, Inc. "WCKY").

5. The Committee agreed to reconvene January 18 at 10:30 AM to review the United Clarification #2.
6. The Committee reviewed the scores to confirm the documentation for scores of Exceeds/Substantially Exceeds were clear and detailed where possible. See *Table 5 – Scoring Validation Exceeds/Substantially Exceeds*.

January 18, 2019

Three separate Meetings were held.

Evaluation Committee Meeting #1 at 10:30 AM

Attendees: Sheila Platts, Melanie Bush, Tabitha Bryant (by phone), Cathy Pace, Amanda Van Vleet, Sabrena Lea, Patrick Doyle, Leadership Mona Moon, Legal Counsel Lotta Crabtree (part phone and in-person), SME Kelsi Knick, Kimberley Kilpatrick and Gregory Sligh.

1. Posed the Confidentiality and Conflict of Interest question to the Committee – no conflicts.
2. United submitted their response to the Clarification #2 request before the 9:00 a.m. deadline. See *Table 2 – Offeror Clarifications* for additional information.
3. The Committee reviewed United's Clarification #2 response. No scores were changed based on the Clarification.
4. The Committee having completed a review and scoring of all questions agreed to meet at 12:00 PM to review the scores for the first time with the understanding that quality assurance activities were on-going and scores would not be final until that process is complete.

Evaluation Committee Meeting #2, 12:00 PM

Attendees: Sheila Platts, Melanie Bush, Tabitha Bryant (by phone), Cathy Pace, Amanda Van Vleet, Sabrena Lea, Patrick Doyle, Leadership Mona Moon, Legal Counsel Lotta Crabtree, Kimberley Kilpatrick and Gregory Sligh.

1. Posed the Confidentiality and Conflict of Interest question to the Committee – no conflicts.
2. A summary of the scores was reviewed and discussed.

Evaluation Committee Meeting #3 at 2:30 PM

Attendees: Sheila Platts, Melanie Bush, Tabitha Bryant (by phone), Cathy Pace, Amanda Van Vleet, Sabrena Lea, Patrick Doyle, Leadership Mona Moon, Legal Counsel Lotta Crabtree (by phone), Leadership Jay Ludlam (briefly by phone), SME Sarah Gregosky, Kimberley Kilpatrick and Gregory Sligh.

1. Posed the Confidentiality and Conflict of Interest question to the Committee – no conflicts.

2. A summary of the scores was reviewed and discussed.
3. The Committee completed a quality assurance review to ensure the scores of Exceeds/Substantially Exceeds were clear, consistent across all Offerors and sufficiently detailed.
4. The next step of the quality assurance process is for Lotta Crabtree to review the scoring of Offeror Client References.

January 22, 2019

Evaluation Committee Meeting

Attendees: Sheila Platts, Amanda Van Vleet, Melanie Bush (by phone), Tabitha Bryant, Cathy Pace, Sabrena Lea, Patrick Doyle, Leadership Mona Moon, Leadership Jay Ludlum, Legal Counsel Lotta Crabtree, SME Sarah Gregosky, Kimberley Kilpatrick and Gregory Sligh.

1. Posed the Confidentiality and Conflict of Interest question to the Committee – no conflicts.
2. As part of the quality assurance process, Kimberley Kilpatrick presented to the Committee her findings when performing a validation in the scoring tools on January 19.
 - a. **AmeriHealth:** Question #47 was scored as “exceeds” in the PHP Consensus Scoring Excel file incorrectly, as the score by the Committee was “meets.” Correction adjusted AmeriHealth from 711.25571 to 706.66204.
 - b. **CCH:** Use Case Scenario #6 in the PHP Consensus Scoring Excel file drop-down box was blank and did not calculate the points for “meets.” Updated box to reflect “meets” and calculate the points. Client Reference #1 had the information correct in the notes, but the drop-down boxes were blank and did not calculate the points for “relevant” and “satisfied.” Correction adjusted CCH from 612.64969 to 628.39969.
 - c. **WellCare:** Use Case Scenario #4 in the PHP Consensus Scoring Excel file drop-down box was blank and did not calculate the points for “meets.” Updated the box to reflect “meets” and calculate the points. This correction adjusted WellCare from 731.99304 to 736.19304.
 - d. Committee confirmed scores and supporting reasons for corrections in the PHP Consensus Scoring Excel file. Corrections made.
3. The Committee also discussed the findings of the overall review of Offeror Client References conducted by Lotta Crabtree.
 - a. The Committee did not initially score BCBS’s reference from BlueChoice Health Plan of South Carolina because they determined it was not a “client” reference (See December 19, #4). However, a reference for Aetna from [REDACTED] was scored. Legal Counsel presented to the Committee that the relationship between BlueChoice Health Plan and Amerigroup and that of Aetna and [REDACTED] appeared similar.
 - b. Following discussion by the Committee it was determined that the reference for Amerigroup Partnership Plan, LLC from BlueChoice Health Plan of South Carolina should be scored for BCBS and the scoring was updated accordingly.

3. A summary of the scores was reviewed and discussed, and the Committee determined its award recommendation to be as follows, based on the scores:
 - a. AmeriHealth Caritas North Carolina, Inc.
 - b. Blue Cross and Blue Shield of North Carolina
 - c. UnitedHealthcare of North Carolina, Inc.
 - d. WellCare of North Carolina
6. The Committee discussed whether to recommend award of a regional contract. Only two Offerors are eligible for regional contracts, CCH and Optima. CCH and Optima are the lowest scoring Offerors by a margin of more than 75 points relative to the fourth highest scoring Offeror. Optima's total score indicates the Offeror, on average, failed to achieve the threshold to "meet expectations," i.e. 60% of the total possible points or 615. Awarding a contract to CCH would result in making an award over higher scoring and more technically capable Offerors. While those higher scoring Offerors are not eligible for regional contracts, the Committee did not recommend an award to CCH given their significantly lower technical score.
7. While the Committee reached consensus on the award recommendation based on the scores, the recommendation was subject to change pending completion of all QA activities and resulting final scores. A final comparison of the handwritten scores and related notes (Scoring Notebook) in the form of *Attachment # 7 PHP Scoring Guide* with the Excel Scoring Spreadsheet, *Attachment #11 PHP Consensus Scoring Excel File*, was still required.

January 24, 2019

Evaluation Committee Meeting

Attendees: Tabitha Bryant, Cathy Pace, Amanda Van Vleet, Sheila Platts (by phone), Melanie Bush (by phone), Sabrena Lea (by phone), Patrick Doyle (by phone), Leadership Mona Moon, Legal Counsel Lotta Crabtree, SME Sarah Gregosky, Kimberley Kilpatrick and Gregory Sligh.

1. Posed the Confidentiality and Conflict of Interest question to the Committee – no conflicts.
2. Meeting called to discuss the final quality review activity of the scores conducted to ensure consistency and accuracy.
3. Sarah Gregosky and Greg Sligh compared the Scoring Notebook with the Excel Scoring Spreadsheet. Three (3) inconsistencies were discovered for question 5., Attachment O. Offeror's Proposal and Response Table 3: Entities performing core functions or with proposed experience as follows:
 - a. BCBS had entity EyeMed Vision Care, LLC listed twice.
 - b. My Health was scored Experience: "Meets" for its entity Community Care Partners of Greater Mecklenburg. All other CCNC Networks were scored Experience: "Exceeds" for the same question.

- c. United had its entity eviCore scored “Substantially Exceeds” in the Scoring Notebook and “Exceeds” in the sExcel Scoring Spreadsheet.

Following discussion by the Committee it was determined that the duplication for BCBS should be deleted, Community Care Partners of Greater Mecklenburg for My Health should be scored “Exceeds” and United’s score for eviCore should be “Substantially Exceeds”.

4. The scoring was updated accordingly but did not change significantly and did not alter the recommendation of the Committee.
5. The Committee confirmed its January 22, 2019 award recommendation based on the final scoring and associated ranking of the offerors as follows:

RFP #30-190029-DHB - Prepaid Health Plans

Highest Scoring Offer, Ranked 1st			736.19304	71.824%
Type of Contract	Rank	Offeror Name	Weighted Total Score	Percentage of Total Possible Points
Statewide	1	WellCare Health Plans	736.19304	71.824%
Statewide	2	United Health Care	727.76474	71.001%
Statewide	3	BCBSNC – Healthy Blue	712.22431	69.485%
Statewide	4	AmeriHealth Caritas North Carolina	706.66204	68.943%
Statewide	5	Aetna	704.60144	68.742%
Statewide	6	My Health by Health Providers	629.71280	61.435%
Either	7	Carolina Complete Health	628.39989	61.307%
Regional	8	Optima Health	573.48539	55.950%

Total Possible Score 1025.00000
Total Possible If All Scores Meet Expectations (80%) 815.00000

Offeror is a PLE

Offeror did not achieve average score of Meets

Table 1 - Offeror Client Reference Check Tracking

	Initial Email Request	Follow Up Email	Follow Up Call with Email	Final Email Request and Determination
Aetna				
[REDACTED]	11/27/2018	12/15/2018	N/A – Returned 12/18/2018	N/A
[REDACTED]	11/27/2018	12/15/2018	01/03/2019 Left message with [REDACTED] and indicated: 1) sent email with reference request on both 11/27/2018 and 12/15/2018; 2) NC Medicaid planned to complete scoring by January 11, 2019; 3) would like to consider all information including this reference; 4) that a follow up email with the request & survey would be sent; and 5) contact information for Kimberley Kilpatrick in the event there were questions.	N/A – Returned 01/04/2019
[REDACTED]	11/27/2018	N/A – Returned 12/13/2018	N/A	N/A
[REDACTED]	11/27/2018	N/A – Returned 11/28/2018	N/A	N/A

Attachment #4 PHP Evaluation Committee Meeting Notes and Timeline

AmeriHealth				
Delaware Department of Health and Social Services (DHSS), Division of Medicaid and Medical Assistance	11/27/2018	12/15/2018	N/A -Returned 12/17/2018	N/A
Louisiana Department of Health (LDH)	11/27/2018	12/15/2018	N/A – Returned 12/21/2018	N/A
Michigan Department of Health and Human Services (MDHHS)	11/27/2018	N/A – Returned 12/14/2018	N/A	N/A
South Carolina Department of Health and Human Services (SCDHHS)	11/27/2018	12/15/2018	01/03/2019 Left message with Bryan Amick (803-898-0212) and indicated: 1) sent email with reference request on both 11/27/2018 and 12/15/2018; 2) NC Medicaid planned to complete scoring by January 11, 2019; 3) would like to consider all information including this reference ; 4) that a follow up email with the request & survey would be sent: and 5) contact information for Kimberley Kilpatrick in the event there were questions.	N/A – Returned 01/03/2019

Attachment #4 PHP Evaluation Committee Meeting Notes and Timeline

BCBS of NC Healthy Blue				
AMGP Georgia Managed Care Company, Inc. (Amerigroup Georgia) as an affiliate of their subcontractor, Amerigroup Partnership Plan, LLC	11/27/2018	12/15/2018	01/03/2019 Left message with Blake Fulenwider (404-657-7739) and indicated: 1) sent email with reference request on both 11/27/2018 and 12/15/2018; 2) NC Medicaid planned to complete scoring by January 11, 2019; 3) would like to consider all information including this reference ; 4) that a follow up email with the request & survey would be sent: and 5) contact information for Kimberley Kilpatrick in the event there were questions.	01/16/2019 Sent email requesting return no later than 9:00 AM 01/17/2019 in order to be considered. Reference not returned and could not be considered.
Amerigroup Partnership Plan, LLC subcontract with BlueChoice Health Plan of South Carolina, Inc.	11/27/2018	12/15/2018	N/A – Returned 12/17/2018 but not scored as it was not considered to be an acceptable Client Reference because it came from BlueChoice HealthPlan of South Carolina and not the state of South Carolina.	1/22/2019 Determination: After quality review check of all references it was determined that the reference from BlueChoice HealthPlan of South Carolina should be scored consistent with the scoring of other client references.

Attachment #4 PHP Evaluation Committee Meeting Notes and Timeline

AMERIGROUP Washington, Inc. as an affiliate of their subcontractor, Amerigroup Partnership Plan, LLC	11/27/2018	12/15/2018	01/03/2019 Left message with Preston Cody (360-725-1786) and indicated: 1) sent email with reference request on both 11/27/2018 and 12/15/2018; 2) NC Medicaid planned to complete scoring by January 11, 2019; 3) would like to consider all information including this reference; 4) that a follow up email with the request & survey would be sent; and 5) contact information for Kimberley Kilpatrick in the event there were questions. As P. Cody was a reference for both BCBS and United HealthCare, the message and email sent 01/03/2019 included follow up for both BCBS and United HealthCare to avoid multiple messages and emails.	01/16/2019 Sent email requesting return no later than 9:00 AM 01/17/2019 in order to be considered. Reference not returned and could not be considered.
AMERIGROUP Maryland, Inc. (AMERIGROUP Maryland) as an affiliate of their subcontractor, Amerigroup Partnership Plan, LLC	11/27/2018	N/A – Returned 12/6/2018	N/A	N/A

Attachment #4 PHP Evaluation Committee Meeting Notes and Timeline

Carolina Complete Health				
Granite State Health Plan, Inc. (d/b/a, NH Healthy Families), as an affiliate of Carolina Complete Health, Inc.	11/27/2018	12/15/2018	N/A – Returned 12/16/2018	N/A
Managed Health Services, Inc. (MHS), as an affiliate of Carolina Complete Health, Inc.	11/27/2018	N/A – Returned 12/7/2018	N/A	N/A
Sunflower Health Plan, Inc., as an affiliate of Carolina Complete Health, Inc.	11/27/2018	N/A – Returned 12/11/2018	N/A	N/A
Superior HealthPlan, Inc. (Texas)	11/27/2018	N/A – Returned 11/29/2018	N/A	N/A
My Health by Health Providers				
[REDACTED]	11/27/2018	N/A – Returned 11/27/2018	N/A	N/A
[REDACTED]	11/27/2018	N/A – Returned 12/13/2018	N/A	N/A
[REDACTED]	11/27/2018	N/A – Returned 12/7/2018	N/A	N/A

Attachment #4 PHP Evaluation Committee Meeting Notes and Timeline

Only provided three (3) client references in response				
Optima				
Department of Medical Assistance Services – PACE	11/27/2018	12/15/2018	01/03/2019 Left message with Barbara McCray (804-225-4385) and indicated: 1) sent email with reference request on both 11/27/2018 and 12/15/2018; 2) NC Medicaid planned to complete scoring by January 11, 2019; 3) would like to consider all information including this reference ; 4) that a follow up email with the request & survey would be sent; and 5) contact information for Kimberley Kilpatrick in the event there were questions.	01/16/2019 Sent email requesting return no later than 9:00 AM 01/17/2019 in order to be considered. Reference not returned and could not be considered.
Huntsville Hospital Health System	11/27/2018	N/A – Returned 12/3/2018, not scored as reference indicated the services were never implemented as contract/project canceled.	N/A	N/A
Department of Medical Assistance Services - Operations	11/27/2018	N/A – Returned 12/12/2018	N/A	N/A

Attachment #4 PHP Evaluation Committee Meeting Notes and Timeline

Department of Medical Assistance Services – Integrated Care	11/27/2018	N/A – Returned 11/28/2018	N/A - Returned	N/A - returned
United HealthCare				
Michigan Department of Health and Human Services	11/27/2018	N/A – Returned 12/14/2018	N/A	N/A
Health Care Authority – Health Care Services	11/27/2018	12/15/2018	01/03/2019 Left message with Preston Cody (360-725-1786) and indicated: 1) sent email with reference request on both 11/27/2018 and 12/15/2018; 2) NC Medicaid planned to complete scoring by January 11, 2019; 3) would like to consider all information including this reference; 4) that a follow up email with the request & survey would be sent; and 5) contact information for Kimberley Kilpatrick in the event there were questions. As P. Cody was a reference for both BCBS and United HealthCare, the message and email sent 1/3/2019 included follow up for both BCBS and United HealthCare to avoid multiple messages and emails.	01/16/2019 Sent email requesting return no later than 9:00 AM 01/17/2019 in order to be considered. Reference not returned and could not be considered.

Attachment #4 PHP Evaluation Committee Meeting Notes and Timeline

Rhode Island Executive Office of Health and Human Services	11/27/2018	N/A – Returned 12/11/2018	N/A	N/A
Kansas Department of Health and Environment Resources (KDHE)	11/27/2018	N/A – Returned 11/28/2018	N/A	N/A
WellCare				
WellCare of Georgia, Inc. (WCGA), as an affiliate of WellCare of North Carolina, Inc.	11/27/2018	12/15/2018	01/03/2019 Left message with Blake Fulenwider (404-657-7739) and indicated: 1) sent email with reference request on both 11/27/2018 and 12/15/2018; 2) NC Medicaid planned to complete scoring by January 11, 2019; 3) would like to consider all information including this reference; 4) that a follow up email with the request & survey would be sent; and 5) contact information for Kimberley Kilpatrick in the event there were questions.	01/16/2019 Sent email requesting return no later than 9:00 AM 01/17/2019 in order to be considered. Reference not returned and could not be considered.

Attachment #4 PHP Evaluation Committee Meeting Notes and Timeline

WellCare of Kentucky, Inc. (WCKY), as an affiliate of WellCare of North Carolina, Inc.	11/27/2018	12/15/2018	01/03/2019 - Jill Hunter referred to Stephanie Bates and did not provide contact info. Left a message with Hunter on 01/03/2019. Using the company directory, located a Stephanie Bates at ext. 2112 and left message for Bates. Sent follow up email to Hunter requesting additional contact info for Bates. Using the first.last@ky.gov format sent to Stephanie.Bates@ky.gov hoping to be received or bounce back. No follow up from Hunter or Bates.	01/16/2019 Sent email requesting return no later than 9:00 AM 01/17/2019 in order to be considered. Returned 01/16/2019 and scored.
WellCare of New Jersey, Inc. (WCNJ), as an affiliate of WellCare of North Carolina, Inc.	11/27/2018	12/15/2018	01/03/2019 – Called <insert name – Grant> at <insert #> and spoke with Paula Kamrad (Grant’s assistant). Resent request and survey copying Ms. Kamrad.	N/A – Returned 01/04/2019
WellCare of Florida, Inc., d/b/a. Staywell Health Plan of Florida (Staywell)	11/27/2018	N/A – Returned 12/4/2018	N/A	N/A

Table 2 – Offeror Clarifications

<i>Offeror Name</i>	<i>Item</i>	<i>Date Sent</i>	<i>Date Received</i>
Aetna	Clarification #1 – Confirm Requirements	January 13, 2019	January 14, 2019
AmeriHealth	Clarification #1 – Confirm Requirements	January 13, 2019	January 14, 2019
BCBS NC Healthy Blue	Clarification #1 – Confirm role of LME/MCOs in response	November 19, 2018	November 20, 2018
	Clarification #2 – Confirm Information for Financial Management Requirements	December 20, 2018	December 20, 2018
Carolina Complete Health	Clarification #1 – Clarify Qualified Health Plan information	November 29, 2018	November 30, 2018
	Clarification #2 – Confirm Requirements	January 13, 2019	January 13, 2019
My Health by Health Providers	None Issued		
Optima	Clarification #1 – Confirm Requirements	January 13, 2019	January 14, 2019
United HealthCare	Clarification #1 – Clarify Qualified Health Plan information	November 29, 2018	December 3, 2018
	Clarification #2 – Clarify the role of LME/MCOs for Care Management of Members	January 17, 2019	January 17, 2019
WellCare	Clarification #1 – Confirm Requirements	January 13, 2019	January 14, 2019

Table 3 – Offeror Negotiation Documents

<i>Offeror Name</i>	<i>Item</i>	<i>Date Sent</i>	<i>Date Received</i>
Aetna	Negotiation Document #1 – Confirm Acceptance of Revisions to Requirements	January 8, 2019	January 10, 2019
AmeriHealth	Negotiation Document #1 – Confirm Acceptance of Revisions to Requirements	January 8, 2019	January 11, 2019
	Negotiation Document #2 – Revised and Restated RFP	January 28, 2019	January 29, 2019
BCBS NC Healthy Blue	Negotiation Document #1 – Confirm Acceptance of Revisions to Requirements	January 8, 2019	January 11, 2019
	Negotiation Document #2 – Revised and Restated RFP	January 28, 2019	January 29, 2019
Carolina Complete Health	Negotiation Document #1 – Confirm Acceptance of Revisions to Requirements	January 8, 2019	January 8, 2019
My Health by Health Providers	Negotiation Document #1 – Confirm Acceptance of Revisions to Requirements	January 8, 2019	January 11, 2019
Optima	Negotiation Document #1 – Confirm Acceptance of Revisions to Requirements	January 8, 2019	January 10, 2019
United HealthCare	Negotiation Document #1 – Confirm Acceptance of Revisions to Requirements	January 8, 2019	January 11, 2019
	Negotiation Document #2 – Revised and Restated RFP	January 28, 2019	January 29, 2019
WellCare	Negotiation Document #1 – Confirm Acceptance of Revisions to Requirements	January 8, 2019	January 11, 2019
	Negotiation Document #2 – Revised and Restated RFP	January 28, 2019	January 29, 2019

Table 4 – Scoring Validation Partially Meets/Does Not Meet

The following tables list, by Offeror, the evaluation questions, consensus score and reason for the Committee's score for each rating recorded as Partially Meets or Does Not Meet. The tables were created to facilitate a quality review of the ratings to confirm the documentation for scores of Partially Meets/Does Not Meet is clear, consistent across all Offerors, sufficiently detailed and reflects the consensus of the Committee.

The scores as referenced in the tables do not reflect the numerical results associated with the ratings. Refer to *Attachment #11 PHP Consensus Scoring Excel File* to see the associated weights and resulting numerical scores for each question and Offeror.

The frequency with which an Offeror received a score of Partially Meets and/or Does Not Meet, in and of itself, does not reflect the Offeror's overall capability or quality of its response and cannot be taken out of context.

Aetna

Evaluation Question #	Score	Reason
10	PM	Did not clearly articulate corrective action plans and, provide description of nature of the sanctions or description of the corrective action plans to prevent future occurrences. repetitive problematic issues in multiple states with ER performance.
25.d	PM	Response demonstrates that the Offeror has a fair understanding of the expectations and proposes an approach that will partially address how the connection between FFS and managed care will be implemented with relation to carved-out services. Specifically, the approach does not meet the expectations for the coordination of FFS dental and eyeglasses. See Section V.C.I.b.iv and Table C.1 of the RFP.
31. Supporting Documentation – Draft NEMT Policy	PM	The response demonstrates the Offeror has a fair understanding of the requirements as the draft NEMT policy provides 2 sample policies that do not include information demonstrating application of any of the minimum requirements stated in Section V.C.5.I.i. that are to be included in the final NEMT Policy.
54. Supporting Documentation – Draft Business Continuity Plan	DNM	Response demonstrates a poor understanding of the expectations as the draft Business Continuity Plan provided as Appendix Q_Q54 is an overview of Aetna's approach and not a draft to address requirements restoring operations in Section V.G.5.b, e.
56. Supporting Documentation – Draft Encounter Implementation Approach	DNM	Response demonstrates a poor understanding of all expectations as it provides a timeline only of activities and does not address the requirements of Section V.K.6.c. Specifically, it lacks the approach to meeting performance, accuracy and timeliness requirements, a staffing and technology model, and other required supporting processes.

AmeriHealth Caritas

Evaluation Question #	Score	Reason
10	PM	Response identifies repeated sanctions with failure to comply with [REDACTED]
22.a	DNM	The response demonstrates that the Offeror has a poor understanding of the expectations noted in V.B.4.j, as the approach does not include a comprehensive estimated timeline of marketing activities, marketing locations, or distribution.
22.b	PM	The response demonstrates that the Offeror has a fair understanding of the expectations noted in V.B.4.g and V.B.4.h and has proposed an approach that is ambiguous and provides very limited information about its proposed plan to meet the needs of our very diverse population.
30.a	PM	The response demonstrates that the Offeror has a fair understanding of the expectations noted in V.C.4, as the draft PHP Transition of Care Policy does not propose an approach that incorporates NC Medicaid's legacy processes and contains considerable gaps in the approach for the continuity of care, as described in V.C.4.c.ii.
33. Supporting Documentation #3 – Comprehensive Assessment Tool	PM	Response demonstrates a fair understanding of all expectations but does not provide an example of a tool that will be utilized for performing care assessments.
34.c	PM	Response demonstrates a fair understanding of the expectations noted in V.C.6.a.v.c and lacked details and supporting information with regards to experience in developing processes and partnerships with SNF, NICUs, hospitals, rehabs, and other levels of care in order to facilitate transitions.
37.a	PM	Response demonstrates a fair understanding of the expectations noted in V.C.7.a-V.C.7.c and lacks explanation of how the Bright Start (maternity care coordination) program will align with the Department's expectations for care management for high-risk pregnant women noted in V.C.6.b.v.
37.b	PM	Response demonstrates a fair understanding of the expectations noted in V.C.7.h, as the "Member Lock-in" program is inconsistent with the Department's expectations.
57.b	PM	The response demonstrates a fair understanding of the expectations noted in V.I.1, as limited information is provided on the approach to managing utilization and expenditures within the capitation payment while meeting or exceeding quality standards, particularly in relation to pharmacy utilization management.
59.a	PM	Response demonstrates a fair understanding of the expectations noted in V.I.3 as the response is ambiguous with regards to establishing claims reserves.

Use Case Scenario #3	PM	Response demonstrates a fair understanding and includes an approach that does not clearly address the services for the Pregnancy Management Care Program for High-risk Pregnant Women, which is a critical component of this Use Case Scenario, and a limited understanding of the roles of the local DSS and Ombudsman Program.
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BCBS Healthy Blue

Evaluation Question #	Score	Reason
10	DNM	Disclosure does not appear thorough because of limited exposure of [REDACTED] that are performing core Medicaid Operation Functions as part of the proposal.
26.e	PM	The response demonstrated that the Offeror has a fair understanding and proposes an approach that does not clearly tie the requirements in Section V.C.1.e to integration.
32.e	PM	Response demonstrates a fair understanding of all expectations as the response does not address historical costs and lessons learned.
33. Supporting Documentation #2 – Care Plan Examples	PM	Response demonstrates a fair understanding of the expectations, but the approach does not reflect person-centered planning as required in Section V.C.6.a.iv.c.3 of the RFP.
56.c, e, f	PM	Response demonstrates a fair understanding of all expectations and proposes an approach that is ambiguous and lacks detail with regards to innovation and data collection as required in the question.
56.g	PM	Response demonstrates a fair understanding of the challenges and associated mitigation approach with EDS, but the response is ambiguous and fails to provide details to implement and support the approach.
Use Case Scenario #3	PM	Response demonstrates a fair understanding and includes an approach that is not cohesive to address the requirements of the Use Case Scenario. The approach is based largely on [REDACTED]

Carolina Complete Health

Evaluation Question #	Score	Reason
8	PM	Ambiguous and limited supportive information on highlighted experience with models for Medicaid Managed Care Members, including the number of lives served, number of providers engaged, and populations served.

10	DNM	Disclosure does not appear thorough because of limited exposure of Centene.
16. Supporting Documentation #1 – Draft Implementation Plan	PM	Draft implementation plan partially met expectations as it provides more of an overall approach, methodology and project management function instead of addressing the items outlined in Section V.A.5.e.
19	PM	The response demonstrates a fair understanding of the requirements of Section V.A.9. of the RFP as the response provides limited information on recruitment with turn over approaches focused primarily on key personnel and without fully addressing their approach for reducing turnover of operational staff; on creative thinking or innovative solutions to ensure compliance; and on interventions to address workforce shortage and outcomes.
25.a	PM	The response demonstrates a fair understanding of the requirements and proposes an approach that partially meets expectations for whole-person, integrated care for medical and behavioral health benefits as specified in Sections V.C.1.a. and V.C.6.a. of the RFP. The response provides limited details and does not sufficiently demonstrate the experience or capability to operationalize the approach. For example, the response omits a discussion of the integration of LTSS and BH beyond the initial screening and proposes use of multiple care management platforms.
25.d	PM	The response demonstrates the Offeror has a fair understanding of requirements and proposes an approach that partially meets expectations as evidenced by response for integration with dental services; however, the response incorrectly states the eyeglass carve out as specified in Section V.C. Table 2: Services Carved Out of Medicaid Managed Care of the RFP and provides limited supporting information on their approach to address the Local Education Agencies carve out.
26.d	PM	The response demonstrated a fair understanding of requirements and expectations. Response provides limited supporting information on the methods and approach for timely access to care for members with the administration of the UM Program as required by Section V.C.1.j.iv.-vi. of the RFP.
32.a	PM	Response demonstrates a fair understanding of the expectations as the approach does not demonstrate the capability to seamlessly implement the Department's expectations for integrated care management as specified in Section V.C.6.a. of the RFP; for example, penetration rates presented in Offeror's response.
32.b	PM	Response demonstrates a fair understanding of the expectations with regards to the role of the LHDs, their approach does not demonstrate the capability to successfully implement the Department's expectations for integrated care management with local network providers as specified in Section V.C.6.b. of the RFP.

32.e	PM	Response demonstrates a fair understanding of requirements and proposes an approach that partially meets the expectations specified in Section V.C.6.a.ii. of the RFP. The response provides limited details and does not sufficiently demonstrate the experience or capability to operationalize the approach such as multiple care management platforms not being clearly integrated.
33. Supporting Documentation #1 – Care Management Workflow	PM	Response demonstrates a fair understanding of the expectations as the care management flow only provides the process flow for one component (person-centered service planning process) of the care management process.
33. Supporting Documentation #2 – Care Plan Examples	PM	Response demonstrates a fair understanding of the expectations as the Care Plan examples do not address the Department's vision for "person-centered" approach. Care Plan examples are deficit-based, and do not demonstrate collaboration with the Member and/or the Member's family.
33. Supporting Documentation #3 – Comprehensive Assessment Tool	PM	Response demonstrates a fair understanding as limited information and details are provided to support the assessment tool requirements to meet the Department's expectations.
35.a.	PM	Response demonstrates a fair understanding of the expectations as the approach does not demonstrate the capability to seamlessly implement the Department's vision for integrated care management. For example, approach includes "co-managing" care managers.
35.c	PM	Response demonstrates a fair understanding of the expectations as the approach does not demonstrate the capability to seamlessly implement the Department's vision for integrated care management. For example, multiple care managers performing duplicative tasks.
57.c	PM	Response demonstrates a fair understanding of all expectations noted in V.I.1 as the response presents a plan for financial predictability of the program that lacks sufficient detail.
57.e	PM	Response demonstrates a fair understanding of all expectations noted in V.I.1 as the response presents measures and targets for each measure that do not align with the Department's draft rate book and lacks context to support how the measures and targets will demonstrate value to DHHS.
59.a	PM	Response demonstrates a fair understanding of all expectations noted in V.I.3 as the response lacks detail on how the Offeror will share financial risk across partner entities.

My Health by Health Providers

Evaluation Question #	Score	Reason
10	PM	Reoccurring performance issues over multiple years including provider complaints, eligibility issues, and nurse call center lines.
22.b	DNM	Response does not demonstrate an approach to address marketing to diverse populations and adopting marketing materials to reach various populations. Offeror acknowledges in response that it has yet to build a marketing approach. See RFP Section V.B.4.g.
25.d	DNM	Response demonstrates a poor understanding of all the expectations and does not propose an approach to NC Medicaid carved out services. See RFP Section V.C.1.b.i
32.c	DNM	Response demonstrates a poor understanding of the expectations and does not meet as the offeror did not provide a response to this component. See RFP Section V.C.6.b.i.
32.d	PM	Response demonstrates limited information on the other case management entity. See RFP Section V.C.6.b.iv.a.
33. Supporting Documentation #2 – Care Plan Examples	PM	Response demonstrates a fair understanding of all expectations and has proposed an approach that partially meets expectations and does not demonstrate the plans were reviewed by the members or were person-centered. See RFP Section V.C.6..iv.c.3.
34.g	PM	Response demonstrates a fair understanding of all expectations as it provides limited information for outcomes/ROIs. Examples did not include the components required within the question.
40.b	PM	Demonstrates a fair understanding and proposes an approach that lacks detail and is ambiguous on process for monitoring compliance. See RFP Section V.D.1.d.ii.a.
40.e	PM	Demonstrates a fair understanding and proposes an approach that lacks detail and is ambiguous on timing and methods of delivery. See RFP Section V.D.1.d.vii.
43.c	PM	The response demonstrates a fair understanding of all expectations and proposes an approach that does not include a timeline for updating their systems for rate changes and does not provide a detailed approach for alternative payment arrangements. See RFP Section V.D.4.b-c.
45	PM	Demonstrates a fair understanding of all expectations and proposes an approach that is incomplete as the QAPIs and race and ethnicity stratifications were not included. The Offeror does not demonstrate the experience to implement a Quality Management and Improvement approach to meet the Department's expectations. See RFP Section V.E.1.e.ii.

47	PM	Response demonstrates a fair understanding that will partially meet the expectations-as it lacks a clear strategy and does not provide details about number of beneficiaries served, volume, types and availability of services. See RFP Section V.F.1.f.i-vii..
52	PM	Response demonstrates a fair understanding of the expectations and the approach is ambiguous and provides limited supporting information on how the offeror will operationalize the requirements. See RFP Section V.G.3.a-f
56.g	PM	Demonstrated a fair understanding of the challenges and associated mitigation approach with EDS, but the response was ambiguous and fails to provide a sufficient level of detail about their approach. See RFP Section V. .H.2.e.i
56. Supporting Documentation – Draft Encounter Implementation Approach	PM	Demonstrated a fair understanding of all expectations with an approach to partially meet expectations. Specifically, the response does not address the minimum requirements of the encounters implementation approach that was in the RFP, See RFP Section V.K.6.c.

Optima

Evaluation Question #	Score	Reason
10	DNM	Disclosure is not thorough due to the limited information provided for [REDACTED] as indicated in response.
13	PM	Demonstrate limited capacity and experience to implement an effective governance structure. The draft PLE Governance Plan contains limited information on the Governance Plan and Operations approach required under RFP Section V.A.2.b.
16. Supporting Documentation #1 – Draft Implementation Plan	PM	Draft implementation plan partially met expectations as it provides a timeline with high level tasks and dates without supporting information for the items outlined in Section V.A.5.e. that are to be included in the implementation plan.
19	PM	Response demonstrates a fair understanding as evidenced by limited information on member services and care management: the visuals related to staffing duties and responsibilities lacked detail (Table 19-2 page 64 of 556): limited details on recruitment and retention of key personnel: limited details on organizational line of responsibility, authority, communication and coordination across the organization. The response does not demonstrate experience in implementing a Prepaid Health Plan. Requirements are stated in RFP Section V.A.9.
20.a	PM	Response demonstrates a fair understanding of all expectations and provides an approach includes limited information on how it will be implemented in NC., and as such does not demonstrate the capability or experience to meet expectations.
20.b	PM	Response acknowledges Offeror will work with DSS and EBCI PHHS. However, the response does not provide a holistic and comprehensive approach to integrate with required entities.

22.a	PM	Response demonstrates a fair understanding and proposes an approach that does not provide a holistic and comprehensive approach to support their proposed marketing locations, distribution method and activities.
24.b	DNM	Response provides a process but does not align with the requirements of the RFP. Specifically, response contradicts federal requirements and states a requirement for a written certification for expedited appeals and contradictory to the RFP requirements in Section V.B.6.d.vii.
24.c,d,e	PM	Response demonstrates a fair understanding of all requirements as it does not demonstrate a comprehensive approach for meeting expectations for all timely processing standards and adhering to required standards.
24.f	PM	Response demonstrates a fair understanding as the provided approach is ambiguous on how information will be tracked and trended in order to use data for program improvements.
24.g	DNM	Response does not include detailed strategies to resolve grievances and appeals and honor the rights of members.
25.d	DNM	Offeror's response demonstrates a poor understanding of all expectations and proposes an approach that uses inadequate tools (example, use of an excel spreadsheet) to support the expectation of sufficient capability and the response includes inaccurate information for by including an outdated list of the carved-out services. (List provided by Offeror was not the list currently allowed by law or as stated in the RFP.)
26.e	PM	Offeror's response demonstrates a fair understanding of all expectations and proposes an approach that does not demonstrate a comprehensive approach to integrate medical and behavioral health services in a UM program. Does not include details for how their clinical leadership and staff are integrated.
31. Supporting Documentation – Draft NEMT Policy	PM	The response demonstrates the Offeror has a fair understanding of the requirements as the draft NEMT policy includes one example that does not include information demonstrating alignment to the minimum requirements stated in Section V.C.5.I.i.
33. Supporting Documentation #2 – Care Plan Examples	PM	Response demonstrates a fair understanding of all expectations and has proposed an approach that partially meets expectations and has proposed an approach that does not demonstrate the plans [REDACTED] [REDACTED] Per Section V.C.6.a.v.(a), Development of Care Plan, §2: “The PHP shall ensure that each Care Plan is individualized and person-centered, using a collaborative approach including Member and family participation where appropriate.”
34.c	PM	Response demonstrates a fair understanding and provides limited supporting information on how the approach will meet the Department's expectations. Specifically, the response indicates Offeror will take a “collaborate approach,” but do not explain how they will achieve meeting the requirements of Section V.C.3.i-iv of RFP.

34.d	PM	Response demonstrates a fair understanding that partially meets the Department's expectation, as the response does not provide a plan for to partner with AMH for the transition of care in a way that provides seamless care for the member and whole-person care management as specified in RFP Section V.C.6.v.c. .
35.a	PM	Demonstrates a fair understanding with regards to the Department's expectation for comprehensive assessment time requirements. Specifically, the requirement indicates 30 days (Section 6.C.6.a.iv while the Offeror provides language for within 90 days.
38.a	PM	Response demonstrates a fair understanding of the Department's expectations with a limited approach addressing unmet health related needs as primarily focused on transportation which is one component of the requirements (RFP Section VC.8.c.)
43	PM	The response demonstrates a fair understanding of all expectations and proposes an approach that does not include information about payments to providers other than physicians (i.e. hospitals, FQHCs/RHCs, IHCPs, public ambulance providers) required within RFP Section V.D.4.d-p.
45	PM	Demonstrates a fair understanding of all expectations and proposes an approach that is incomplete and did not include detailed did not included and the stratifications listed for 45.b were incomplete.
52	PM	Response demonstrates a fair understanding of the expectations and partially meets expectations as the proposed reporting templates and/or key fields are not provided as required. See Offeror's Attachment O.Q52 where the information and supporting details is not provided for the templates and key fields.
54. Supporting Documentation – Draft Business Continuity Plan	DNM	Response demonstrates a poor understanding of the expectations as the plan submitted is very high level and does not provide [REDACTED]
56.c,e,f	PM	Demonstrates a fair understanding of all the expectations and proposes an approach that will partially meet the expectations by providing limited supporting information on the use of PACDR and on working with providers on internal operations and correcting encounter errors (components e and f of question).
56.g	PM	Demonstrates a fair understanding of all the expectations and proposes an approach that lacks details on duplicate submissions, sub-capitated claims, specific steps taken to remediate issues, and specific data on outcomes achieved. .

61	PM	Response demonstrates a fair understanding of all expectations and proposes a process for the suspension or withholds of payment to providers that is inconsistent with the requirements of the RFP Section V.2.b.iv.c., For example, the response provides language that the suspension will follow RFP requirements unless Offeror can show good cause not to suspend payment in part or in whole
62	PM	Response demonstrates a fair understanding of all expectations and proposes an approach that fails to include a draft Fraud, Waste and Abuse plan with sufficient details to address the requirements in RFP Section V.J.3.e.iii.a) – q).
Use Case Scenario #4	PM	Response demonstrates a fair understanding and does not provide an approach to timely meet the unmet health related needs. Examples include delays for activities such as medication reconciliation and care needs screening.
Use Case Scenario #5	PM	Response demonstrates a fair understanding with an approach that provides limited information on services such as LTSS and integration with AMHs.

United HealthCare

Evaluation Question #	Score	Reason
10	DNM	Disclosure is not thorough and limited information on [REDACTED].
16. Supporting Documentation #1 – Draft Implementation Plan	PM	Draft implementation plan partially met expectations as it provides a [REDACTED] without supporting information for the items outlined in Section V.A.5.e. that are to be included in the implementation plan.
25.a	PM	Offeror's response demonstrated a fair understanding of all expectations as the response does not meet the Department's expectations for Care Management. The approach indicates [REDACTED] which is inconsistent with the Department's expectation for integrated whole-person care. See RFP Section V.C.6.a.i.-iii and V.C.6.b.i-ii.
26.e	PM	Offeror's response demonstrated a fair understanding of all expectations as the response does not meet the Department's expectations for Care Management. The approach indicates [REDACTED] which is inconsistent with the Department's expectation for integrated whole-person care. See RFP Section V.C.6.a.i.-iii and V.C.6.b.i-ii.
26.f	PM	Offeror's response demonstrated a fair understanding of all expectations as the response does not meet the Department's expectations for Care Management. The approach indicates [REDACTED] which is inconsistent with the Department's expectation for integrated whole-person care. See RFP Section V.C.6.a.i.-iii and V.C.6.b.i-ii.

32a	PM	Offeror's response demonstrated a fair understanding of all expectations as the response does not meet the Department's expectations for Care Management. The approach indicates that [REDACTED] which is inconsistent with the Department's expectation for integrated whole-person care. See RFP Section V.C.6.a.i.-iii and V.C.6.b.i.-ii. Specifically, the approach has [REDACTED] is not an approach that aligns with whole-person care.
32.b	PM	Offeror's response demonstrated a fair understanding of all expectations as the response does not meet the Department's expectations for Care Management. The approach indicates that [REDACTED] which is inconsistent with the Department's expectation for integrated whole-person care. See RFP Section V.C.6.a.i.-iii and V.C.6.b.i.-ii. Specifically, the approach has [REDACTED] is not an approach that aligns with whole-person care.
32.c	PM	Offeror's response demonstrated a fair understanding of all expectations as the response does not meet the Department's expectations for Care Management. The approach indicates that [REDACTED] which is inconsistent with the Department's expectation for integrated whole-person care. See RFP Section V.C.6.a.i.-iii and V.C.6.b.i.-ii. Specifically, the approach has [REDACTED] is not an approach that aligns with whole-person care.
32.d	PM	Offeror's response demonstrated a fair understanding of all expectations as the response does not meet the Department's expectations for Care Management. The approach indicates that [REDACTED] which is inconsistent with the Department's expectation for integrated whole-person care. See RFP Section V.C.6.a.i.-iii and V.C.6.b.i.-ii. Specifically, the approach has [REDACTED] is not an approach that aligns with whole-person care.
33.d	PM	Offeror's response demonstrated a fair understanding of all expectations as the response does not meet the Department's expectations for Care Management. The approach indicates that [REDACTED] which is inconsistent with the Department's expectation for integrated whole-person care. See RFP Section V.C.6.a.i.-iii and V.C.6.b.i.-ii. Specifically, the approach has [REDACTED] is not an approach that aligns with whole-person care.

33. Supporting Documentation #2 – Care Plan examples	PM	Response demonstrates a fair understanding of all expectations and has proposed an approach that partially meets expectations and has proposed an approach that does not demonstrate the plans were [REDACTED] [REDACTED] Per Section V.C.6.a.v.(a), Development of Care Plan, §2: “The PHP shall ensure that each Care Plan is individualized and person-centered, using a collaborative approach including Member and family participation where appropriate.”
34.a	PM	Offeror's response demonstrated a fair understanding of all expectations as the response does not meet the Department's expectations for Care Management. The approach indicates that [REDACTED] [REDACTED] which is inconsistent with the Department's expectation for integrated whole-person care. See RFP Section V.C.6.a.i.-iii and V.C.6.b.i-ii.
34.d	PM	Offeror's response demonstrated a fair understanding of all expectations as the response does not meet the Department's expectations for Care Management. The approach indicates that [REDACTED] [REDACTED] which is inconsistent with the Department's expectation for integrated whole-person care. See RFP Section V.C.6.a.i.-iii and V.C.6.b.i-ii.
34.f	PM	Response demonstrates a fair understanding of all expectations and has proposed an approach that partially meets expectations and has proposed an approach that is ambiguous on staffing model and staffing ratio.
43	PM	The response demonstrates a fair understanding of all expectations and proposes an approach that does not include a timeline for updating their systems for rate changes and does not provide a detailed approach for alternative payment arrangements. Question 43 states: “Include in your response: a) Description of the processes the PHP will have in place to ensure provider payment requirements are met. Include in your response how quickly the PHP can update its claim system to incorporate changes to provider contracting terms or to rate floors or schedules.” and c) “Description of any alternative payment arrangements the PHP plans to offer providers in lieu of the rate floor.”
56. Supporting Documentation – Draft Encounter Implementation Plan	DNM	Demonstrates a poor understanding of all expectations with an approach that will not meet expectations. Specifically, the response does not address the minimum requirements of the encounters implementation approach that was in the RFP (Section V.K.6.c.).
57.e	PM	Response demonstrates a fair understanding of all expectations as the response does not provide specific measures and targets for each measure. Did not fully answer the question as asked. Question 57 states: “The response shall include: e. Measures and the targets for each measure that the Offeror will use to demonstrate value to the Department.” The response included generalizations; we asked for measures and targets.

WellCare


Evaluation Question #	Score	Reason
9	PM	Disclosure appears thorough and minor concerns with some of the reasons for termination/non-renewal associated with Meridian and other non-re-procurements.
10	PM	Repeated violations related to SLAs in multiple states such as with encounters, payments and financial reporting.
Use Case Scenario #3	PM	Response demonstrates a fair understanding as the response does not fully address the components of the scenario. Specifically, the response does not include an approach that shows the interaction between Health Plan Care Management and Pregnancy Management Care Program for High-risk Pregnant Women in support of whole-person centered care.

Table 5 – Scoring Validation Exceeds/Substantially Exceeds

The following table lists, by Offeror, the evaluation questions, consensus score and reason for the Committee's score for each rating recorded as Exceeds or Substantially Exceeds. The tables were created to facilitate a quality review of the ratings to confirm the documentation for scores of Exceeds/Substantially Exceeds is clear, consistent across all Offerors, sufficiently detailed and reflects the consensus of the Committee.

The scores as referenced in the tables do not reflect the numerical results associated with the ratings. Refer to *Attachment #11 PHP Consensus Scoring Excel File* to see the associated weights and resulting numerical scores for each question and Offeror.

The frequency with which an Offeror received a score of Exceeds and/or Substantially Exceeds, in and of itself, does not reflect the Offeror's overall capability or quality of its response and cannot be taken out of context.

#	Aetna	AmeriHealth	BCBS	CCH	My Health by Health Providers	Optima	United HealthCare	WellCare
6	Exceeds		Exceeds				Exceeds	Exceeds
	Experience serving similar populations in 15 states, very good understanding of transitioning from FFS to managed care in multiple states, clearly demonstrates their philosophy and approach to integrating the Department's goals into daily operations. See Table 6-1 of Aetna's response.		Comprehensive strategy and approach for building on the collective experience in NC (Medicare, NC's State Health Plan), and partnership with Amerigroup (20 of 22 states for integrated care, 6 million members) to transition from FFS to managed care.				Demonstrates a very good understanding of NC historic primary care and behavioral health networks, and their approach builds upon their 	Demonstrates a very good understanding of the State's expectations for Managed Care service delivery and proposes an approach with a single point of contact to streamline access for members and providers with supporting outcome metrics. Table 6-1 provides the 6 states where WellCare has supported the transition for Medicaid FFS to Managed Care.

Attachment #4 PHP Evaluation Committee Meeting Notes and Timeline

#	Aetna	AmeriHealth	BCBS	CCH	My Health by Health Providers	Optima	United HealthCare	WellCare
8	Exceeds				Exceeds		Exceeds	Exceeds
	Approach utilizes an existing state-wide medical home model that has a well established ,evidenced based practice, and connection to local communities. Table 8-1 provides details on Aetna's Medicaid medical home model experience.				Builds upon demonstrated success of NC Medicaid Home Networks with partners who plan to strengthen the role of PCCM and care coordination. See table on page 37 of 498 that provides Offeror's PCMH Development Strategy.		Demonstrates a thorough and complete understanding of medical home model (344 health homes [REDACTED] and articulates a willingness to [REDACTED] primary care management and care coordination.	Demonstrates a very good understanding with an approach that utilizes CCNC's established localized network and WellCare's establish medical home development program (ADVANCE). Proven medical home experience in multiple states. See Table 8-1 in Offeror's response.
12			Exceeds					
			Articulates a very good understanding of NC Medicaid stakeholders as BCBS currently engages Providers, members and other stakeholders through listening sessions, focus groups and other forums to support the transition to managed care and					

Attachment #4 PHP Evaluation Committee Meeting Notes and Timeline

#	Aetna	AmeriHealth	BCBS	CCH	My Health by Health Providers	Optima	United HealthCare	WellCare
			drive program improvements.					
16 Part 1 – Overall Approach	Exceeds	Exceeds	Exceeds				Exceeds	
	Proposes an approach that is concise, detailed and comprehensive; demonstrates a very good understanding of the requirements for successfully launching a managed care program.	Demonstrates a very good understanding of the implementation and readiness requirements providing a detailed and comprehensive approach to successfully launching a managed care plan.	Demonstrates a very good understanding and provides a detailed description of how they will utilize their IMO to drive their processes for implementation of managed care and provided details on implementation staffing structure.				Very good understanding of implementation plan and readiness. Demonstrated track record of successful implementation across multiple states.	
17	Exceeds							
	Demonstrates a very good understanding of all expectations for the Department's non-discrimination requirements, as the response clearly articulates the approach on cultural competency and language access currently integrated in company's operating culture.							

Attachment #4 PHP Evaluation Committee Meeting Notes and Timeline

#	Aetna	AmeriHealth	BCBS	CCH	My Health by Health Providers	Optima	United HealthCare	WellCare
	IN 2017, Aetna was included for the 11 th time on DiversityInc's list of the top 50 companies for diversity.							
19			Exceeds					
			Identifies a robust approach to staffing and training, identifies several approaches for providing training, staffing approach addresses all areas and clearly defines roles, indicates a pro-active approach to address short and long term staffing with succession planning, maintains an innovation studio, identifies innovations to address medical deserts, nursing schools, community health workers, approach demonstrates a very good understanding of the Department's requirements for					


Attachment #4 PHP Evaluation Committee Meeting Notes and Timeline

#	Aetna	AmeriHealth	BCBS	CCH	My Health by Health Providers	Optima	United HealthCare	WellCare
			whole-person integrated care.					
20.a	Exceeds		Exceeds					Exceeds
	Response demonstrates a very good understanding and approach to the continuity of care; response demonstrates a comprehensive, detailed and cohesive understanding of all components of the enrollment and disenrollment process.		The response demonstrates a very good understanding with a proactive approach that is useful and brings added value to the Department. Approach includes a Lexis Nexis member point solution and capability to supplement member information, bar coding member ID card mailing and tracking.					Demonstrates a very good understanding and provides a detailed approach that includes a current relationship with NC's Enrollment Broker in four states, which adds value to the Department during integration. Response demonstrates the existing capacity and capability to timely enroll and disenroll member as evidenced by 500k transactions processed per day in 12 Medicaid markets.
21.a	Exceeds		Exceeds	Exceeds	Exceeds		Exceeds	Exceeds
	The response demonstrates that the Offeror has a very good understanding and approach for member engagement; the approach includes holding town hall		The response demonstrates a very good understanding with a complete and comprehensive approach that includes examples of engaging	The response demonstrated a very good understanding and proposes a comprehensive strategic approach that includes tactics for early member	The response demonstrates a very good understanding of all expectations and a clear approach to operationalization member engagement; the		Demonstrated a very good understanding of all expectations and proposes an approach that exceeds expectations that incorporates Healthified web-	Demonstrated a very good understanding and exceeds expectations with an overall strategy for engaging members by providing a multi-prong approach

Attachment #4 PHP Evaluation Committee Meeting Notes and Timeline

#	Aetna	AmeriHealth	BCBS	CCH	My Health by Health Providers	Optima	United HealthCare	WellCare
	meetings monthly for the first year in addition to the regional advisory committee meetings, a comprehensive member orientation program, video, texting and mapping communications and health and wellness videos.		members in a multi-platform approach that includes mobile fleet to meet members "where they are", 24 hr. assistance lines, mobile approach that incorporates culturally competent materials.	engagement and ongoing tactics to support member engagement. Includes initiatives such as connecting welcome calls to the completion of care needs screening and detailed identification of focal points for community engagement.	response provides information specific to the social determinates components, community engagement, member engagement process flow, whole person/family based, and a comprehensive approach for engagement tools and methods.		based data base used to connect members to resources to address social determinates, [REDACTED] web application/mobile app for access, list sample engagement initiatives and partnerships with Boys & Girls Club/other community partners.	using high tech and high touch engagement strategies, such as brick and mortar and mobile welcome rooms, welcome videos, mobile application "CMS Blue Button Functionality", caregivers support system.
21.b		Exceeds						
		The response demonstrates a very good understanding and provides a proactive approach of [REDACTED] community health workers in FQHCs, health centers, hospitals, and emergency departments.						
22.a			Sub Exceeds					
			The response demonstrates an					

Attachment #4 PHP Evaluation Committee Meeting Notes and Timeline

#	Aetna	AmeriHealth	BCBS	CCH	My Health by Health Providers	Optima	United HealthCare	WellCare
			<p>excellent understanding by providing a complete and comprehensive approach that includes a very detailed plan on the timing of the</p>  <p>See Tables 22-2, Table 22-3 and Table 22-4.</p>					
22.b			Exceeds	Exceeds				Exceeds
			<p>The response demonstrates a very good understanding of NC's diverse populations and cultural disparities, and proposes an approach that tailors materials to address regional and local audiences as evidenced by the sample marketing materials.</p>	<p>The response demonstrates a very good understanding of the diversity of NC members and proposes a comprehensive approach to adapt marketing strategies and materials to those audiences as evidenced by partnerships that currently serve difficult to reach</p>				<p>Demonstrates a very good understanding of NC's geographical and cultural diversity, and the importance of customizing marketing materials to reflect that diversity. Provides a detailed approach that is specific to align with the diverse populations of</p>


Attachment #4 PHP Evaluation Committee Meeting Notes and Timeline

#	Aetna	AmeriHealth	BCBS	CCH	My Health by Health Providers	Optima	United HealthCare	WellCare
				populations by targeting community partners such as Western Carolina Community Health Services and NC Coalition Against NC Violence.				each region. See page 236 of 795.
24.c, d, e				Exceeds				
				The response demonstrates a very good understanding of all expectations by providing a very detailed and comprehensive approach for the monitoring and oversight of the grievances and appeals process to have the necessary protocols, procedures and staffing in place to meet all timeliness standards.				
24.f	Exceeds			Exceeds	Exceeds			
	The response demonstrates a very good understanding and proposes an approach that			The response demonstrates a very good understanding with an approach that demonstrates	Response demonstrates a very good understanding by providing a detailed approach			

Attachment #4 PHP Evaluation Committee Meeting Notes and Timeline

#	Aetna	AmeriHealth	BCBS	CCH	My Health by Health Providers	Optima	United HealthCare	WellCare
	provides a well-defined process for using data to drive system improvements and includes a detailed example of program improvements in another state.			a holistic review across the program to track and trend data, and utilize different methods for make program improvements. Provides specific details such as root-cause analysis and submission of data for recommendations supporting quality improvements	for tracking/trending data to drive quality and process improvements. See Exhibit 24-2 Member Grievance and Appeals Process Overview and Exhibit 24-5 Process Improvement with Grievance and Appeals Data.			
25.a	Exceeds	Exceeds	Exceeds					
	The response demonstrates a very good understanding and proposes an approach that has an emphasis on the behavioral health integration component and social determinates of health and whole-person care. Includes additional focus on provider transformation. See Table 25-1 for nationwide whole-person experience for supporting documentation.	Response demonstrates a very good understanding and proposes an approach that builds on Offeror's experience to integrate medical and behavioral health by providing primary care providers for behavioral health screening, recognizes that addressing social determinates of health is a component to whole-person care, and utilizes a	Response demonstrates a very good understanding and proposes an approach that includes an integrated care management IT platform (Health In Tech), utilizes consultants for proactive integration, value based purchasing arrangement, and a multi-discipline care team that covers all areas.					

Attachment #4 PHP Evaluation Committee Meeting Notes and Timeline

#	Aetna	AmeriHealth	BCBS	CCH	My Health by Health Providers	Optima	United HealthCare	WellCare
		proprietary suite of customized VBP models and alternative payment models to improve whole-care.						
25.b	Exceeds	Exceeds					Exceeds	Exceeds
	The response demonstrates a very good understanding of expectations and proposes an approach that includes the use of a community pharmacy enhanced network, a detailed approach on alignment with action plan and a well-defined opioid strategy. See Table 25-2.	Response demonstrates a very good understanding and proposes an approach that incorporates the needs of Members with substance abuse disorders, the "living beyond pain program", and the neonatal abstinence program. Approach includes working with providers by incentivizing screenings with a value-based program and increasing the number of available MAT and SBIRT trained providers.					Response demonstrates a very good understanding and proposes a comprehensive approach that  address all requirements. See the Table on page 377 of 862.	Response demonstrates a very good understanding and proposes an approach that is strategic and comprehensive. The approach addresses the Provider practice transformation, WellCare staffing and training, and Member resources to provide integrated whole-person care. See Table 25-1 and Table 25-2.
25.c			Sub Exceeds				Exceeds	

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#	Aetna	AmeriHealth	BCBS	CCH	My Health by Health Providers	Optima	United HealthCare	WellCare
			The response demonstrated an excellent understanding and proposes approach that exceeds expectations by including a clear comprehensive plan that addresses all regions, specific entities that they will collaborate with, network development process, and expanding services with outreach at schools and centers for rural health innovation. See Figure 25-3 and Figure 25-4.				Offeror's response demonstrates a very good understanding and proposes a multi-faceted approach that includes provider and member connectivity strategies, and significant successful experience in other state markets.	
25.d								Sub Exceeds
								Demonstrates an excellent understanding of all expectations and proposes a comprehensive approach to assist members in gaining access to all carved out services. See Table 25-5.

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#	Aetna	AmeriHealth	BCBS	CCH	My Health by Health Providers	Optima	United HealthCare	WellCare
26.c					Exceeds		Exceeds	Exceeds
					Response demonstrates a very good understanding of the expectations and requirements and proposes an approach that includes no referrals for specialists and Gold Card option for providers that demonstrate a low adverse determination rate.		Response demonstrated a very good understanding of all expectations and proposes a comprehensive approach that [REDACTED]	Response demonstrates a very good understanding of the expectations and requirements and proposes an approach that includes gold carding for higher quality performing providers and focus on ongoing prior authorization reviews.
26.e								Exceeds
								Response demonstrates a very good understanding of the expectations and requirements and proposes a comprehensive approach that includes an integrated centralized UM platform, an integrated clinical leadership oversight and staff that are cross trained on medical and behavior health.

Attachment #4 PHP Evaluation Committee Meeting Notes and Timeline

#	Aetna	AmeriHealth	BCBS	CCH	My Health by Health Providers	Optima	United HealthCare	WellCare
28.a		Exceeds				Exceeds		
		Demonstrates a very good understanding of the expectations and proposes an approach that provides multiple examples for communication and education such as family-link, Bright Start maternity management program with associated incentives and personalized member communications. Provider awareness includes "Let Us Know Program" and incentivizes PCPs with VBP contracting to educate members on EPSDT.				Demonstrates a very good understanding of all expectations and proposes an approach that includes multi-prong engagement methods that meets the members "where they are" such as presence in schools and information for teen engagement.		
28.c			Exceeds		Exceeds		Exceeds	Exceeds
			Demonstrates that the Offeror has a very good understanding and proposes a proactive approach that utilizes multiple strategies which include an		Demonstrates a very good understanding of challenges related to engaging some members as evidenced by a multi-prong engagement process utilizing		Demonstrates a very good understanding of all expectations by using a multi-modal approach to reach members through communication activities and their	Response demonstrates a very good understanding of all expectations and proposes a comprehensive approach using multi-prong methods to

Attachment #4 PHP Evaluation Committee Meeting Notes and Timeline

#	Aetna	AmeriHealth	BCBS	CCH	My Health by Health Providers	Optima	United HealthCare	WellCare
			effective use of the data analytics platform to identify needs and outreach to the members including deploying mobile health vans.		technology and one-on-one contact with members by CHW. See Exhibit 28-1		network providers, including calls, mailers, child scorecard, baby block program and various messaging options.	ensure they "meet families where they are", including heat maps, healthy rewards incentives, texts, and care alerts.
29.b	Exceeds		Exceeds	Exceeds			Exceeds	Sub Exceeds
	Response demonstrates a very good understanding and proposes a comprehensive care management focus outlined in Table 29-2 on pages 415-416 of 817 in Offeror's response.		Response demonstrates a very good understanding and proposes an approach that details the multiple programs (see pages 268-270 of 784) for supporting and promoting appropriate medication use.	The response demonstrates a very good understanding and proposes an approach that includes a care management model for providing pharmacy benefits. See Table 1 on page 482-483 of 1109 for supporting details.			Response demonstrates a very good understanding and proposes an approach that will engage with member handbooks, member website, targeted letters and the use of technology.	Response demonstrates an excellent understanding and proposes an approach that includes detailed information on engaging members to understand pharmacy benefits and the clinical services that promote medication use and adherence. (See Table 29-1 on pages 317-318 of 795 of Offeror's response).
29.d				Exceeds				Exceeds
				The response demonstrates a very good understanding and proposes a comprehensive approach that				Response demonstrates a very good understanding and proposes an approach that includes detailed

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#	Aetna	AmeriHealth	BCBS	CCH	My Health by Health Providers	Optima	United HealthCare	WellCare
				clearly addresses emergency management and disaster recovery for providing medication during disasters.				processes that are proactive by identifying and contacting at-risk Members prior to disasters to educate and facilitate delivery of medication during the disasters.
29.e	Exceeds							Exceeds
	Response demonstrates a very good understanding and proposes an approach that includes a well-coordinated integration outlining specific roles and responsibilities indicated in Table 29-3 on pages 418-419 of 817 in Offeror's response.							Response demonstrates a very good understanding and proposes an approach that includes details for internal control of quality clinical programs, PAs, formulary and call center management, and acknowledges that spread pricing is not allowed.
30.a			Exceeds					Exceeds
			The response demonstrated that the Offeror has a very good understanding of requirements and proposes a detailed approach that clearly defines how they					Response demonstrates a very good understanding of all expectations and proposes a comprehensive and detailed approach including

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#	Aetna	AmeriHealth	BCBS	CCH	My Health by Health Providers	Optima	United HealthCare	WellCare
			will address the needs of members with special conditions, red flags and medication reconciliation programs.					establishing trusted partnerships, creating a rapid response transition team and identifying high needs members.
31.b	Exceeds	Exceeds	Exceeds		Exceeds		Exceeds	Exceeds
	Response demonstrates a very good understanding and proposes an innovative approach that incorporates relay-ride, door to door tool, e.g. gated community or door pickup request for assistance. Approach links to Google maps/traffic delays, command center that proactively monitors the live trips, level of detail provided indicates a mature and sophisticated technology approach.	Response demonstrates a very good understanding and proposes an approach that incorporates a SUD flexible recovery benefit, door to door services, geographic and demographic nuances as well as internet and app technology that provides an innovative platform for transportation services.	Response demonstrated a very good understanding of requirements and proposes a detailed approach that expands the required transportation requirements of the RFP by [REDACTED] use of technology and use of mobile health vans to bring health to members.		Response demonstrates a very good understanding and deploys an approach with innovative technology for scheduling and communication for both members and providers. See Exhibits 31-1 Design Process, 31-2 Algorithm Description, 31-3 Request a Ride, and 31-4 Scheduled Ride.		Response demonstrated a very good understanding by utilizing the [REDACTED]	Response demonstrates a very good understanding and proposes an approach that includes the use of technology via an app, Relay RIDE (Figure 31-1) for day to day health related needs, and strategies to reduce ED utilization.
31.c								Exceeds


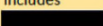
Attachment #4 PHP Evaluation Committee Meeting Notes and Timeline

#	Aetna	AmeriHealth	BCBS	CCH	My Health by Health Providers	Optima	United HealthCare	WellCare
								Response demonstrates a very good understanding and proposes an approach that includes an oversight model addressing cultural sensitivity, defensive driving training, and first aid/CPR training for all drivers.
31. Supporting Documentation – Draft NEMT Policy			Exceeds	Exceeds			Exceeds	
			The response demonstrates a very good understanding with a comprehensive draft policy detailing the purpose, scope, definitions, policy requirements, monitoring and procedures. See Attachment O. 3.31-1.	The response demonstrates a very good understanding with a comprehensive draft policy detailing the scope, policy, and extensive procedures. See Attachment O. 3.31 CCH NEMT Policy.			The response demonstrates a very good understanding with a comprehensive draft policy detailing the scope, purpose, policies and procedures, and monitoring. See Attachment O.3.31 – NEMT Policy.	
32.a					Exceeds			Exceeds


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#	Aetna	AmeriHealth	BCBS	CCH	My Health by Health Providers	Optima	United HealthCare	WellCare
					Response demonstrates a very good understanding and proposes an approach that provides seamless care management that aligns with the Department's vision as evidenced by a sophisticated single platform and high penetration rates. See Exhibit 32-2 My Health's Sophisticated Population Health and Care Management Platform, and Exhibit 32-4 Risk Stratification Levels, Associated Interventions, Staffing, and Estimated Penetration.			Response demonstrates a very good understanding and proposes a comprehensive approach that addresses social determinates at all levels, a community impact model, member stratification and penetration rates that support the capacity to implement the Department's vision for care management. See Table 32-2 Penetration Strategies for Priority Population, Table 32-3 Interventions by Risk Level, and Table 32-4 Staffing Levels by Stratification.
32.b					Exceeds	Exceeds		Exceeds
					Response demonstrates a very good understanding and proposes an approach that includes a comprehensive and detailed plan	Response demonstrates a very good understanding and proposes an approach that includes a detailed [REDACTED]		Response demonstrates a very good understanding and proposes an approach that provides practice transformation support, oversight

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#	Aetna	AmeriHealth	BCBS	CCH	My Health by Health Providers	Optima	United HealthCare	WellCare
					for care coordination with all priority populations. See Exhibit 32-5 My Health and AMH Roles for Delivering Care Management.	 See Table 32-3 Care Management Tasks and Proposed Delegation by Tier.		and infrastructure that adds value to local care management networks. See Figure 32-5 Support for Local Care Management.
32.e	Exceeds							Exceeds
	Response demonstrates a very good understanding and proposes an approach that facilitates member communication with providers and care team through a single point of entry process and access information about community resources and opportunities for health.							Response demonstrates a very good understanding and proposes an approach that facilitates coordinated care among all partners, allows member access to health information, leverages an existing platform for seamless integrations and expands the use of ADT information.
33.b	Exceeds					Exceeds	Exceeds	Exceeds
	Response demonstrates a very good understanding and proposes a details approach that identifies additional priority					Response demonstrates a very good understanding and proposes an approach that identifies additional priority	Response demonstrates a very good understanding and proposes an approach that includes 	Response demonstrates a very good understanding and proposes a detailed approach that includes detailed

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#	Aetna	AmeriHealth	BCBS	CCH	My Health by Health Providers	Optima	United HealthCare	WellCare
	populations and demonstrates the effectiveness of their risk scoring and stratification approach. See Table 33-2 Methods to Identify Members of Priority Populations.					populations and utilizes a StratusPoint system. Also, see Table 33-1 Effectiveness of Care Management Stratification.	 See the Table on page 441 of 862.	definitions of additional priority populations and incorporation of CDPS risk score model. See Figure 33-4 Identification and Stratification Process
33.c								Exceeds
								Response demonstrates a very good understanding and proposes an approach that is not entirely deficit based and includes person-centered principles, leverages CCNC experience, and is specific about the variation in comprehensive assessment for the different priority populations.
33.d	Exceeds	Exceeds						
	Response demonstrates a very good understanding and proposes an approach that	Response demonstrates a very good understanding and proposes an approach that						

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#	Aetna	AmeriHealth	BCBS	CCH	My Health by Health Providers	Optima	United HealthCare	WellCare
	focuses on the Member's care plan, incorporates caregivers, and has a continual review process	focuses on the Member's care plan, incorporates care givers, and has a continual review process.						
33. Supporting Documentation #1 – Care Management Workflows					Exceeds			
					Demonstrates a very good understanding and provides detailed care management workflows illustrating			
33. Supporting Documentation #2 – Care Plan Examples	Exceeds							Exceeds

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#	Aetna	AmeriHealth	BCBS	CCH	My Health by Health Providers	Optima	United HealthCare	WellCare
	Response demonstrates a very good understanding and provides documentation that incorporates [REDACTED]							Response demonstrates a very good understanding and provides documentation that incorporates person-centered planning; specifically, goal statements and issues/problems, and solutions/goals that are member focused.
33. Supporting Document #3 – Assessment Tool	Sub Exceeds		Exceeds					Sub Exceeds
	Response demonstrates an excellent understanding and proposes an approach that includes a comprehensive tool that is adaptable for all populations as evidenced by queries addressing milestones for children, support needs for older adults and their [REDACTED]		Response demonstrates a very good understanding and provides a comprehensive approach that addresses [REDACTED]					The response demonstrates an excellent understanding and proposes an approach that includes a comprehensive tool that is adaptable for all [REDACTED]

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#	Aetna	AmeriHealth	BCBS	CCH	My Health by Health Providers	Optima	United HealthCare	WellCare
	caregivers. The tool is user friendly for assessors.							
34.b					Exceeds			
					Response demonstrates a very good understanding and proposes an innovative use of			
34.c					Exceeds			
					Response demonstrates a very good understanding and proposes an approach that leverages the SMART Transitions Plan for re-admissions. See Exhibit 34-2 SMART Transitions			
35.b							Exceeds	
							Response demonstrates a very good understanding and has proposed an approach that includes	

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#	Aetna	AmeriHealth	BCBS	CCH	My Health by Health Providers	Optima	United HealthCare	WellCare
35.c	Exceeds							Exceeds
	Response demonstrates a very good understanding and proposes an approach that provides quality LTSS outcomes, identifies the member as a decision maker of LTSS needs, details interRAI home care assessment coupled with the HCBS needs tool, and includes caregiver support.							Response demonstrates a very good understanding o and proposes an approach that provides quality LTSS outcomes, identifies the member as decision maker of LTSS needs, integrates care compass, includes caregiver support, and timely face to face interaction with Members.
35.e					Exceeds			
					Response demonstrates a very good understanding and proposes an innovative use of a dashboard to verify Member's level of care by tracking over- and underutilization of services and multiple ED admissions, and EVV monitoring			
36.b	Exceeds							

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#	Aetna	AmeriHealth	BCBS	CCH	My Health by Health Providers	Optima	United HealthCare	WellCare
	Response demonstrates a very good understanding and provides an approach that includes experience in meeting unmet unrelated health needs, knowledge of local and community resources and initiatives, and care management follow-up to ensure "unmet needs" are addressed. See Table 36-1.							
36.c		Exceeds	Exceeds					
		Response demonstrates a very good understanding and proposes a detailed approach utilizing several strong partners in North Carolina who will expand the capacity of and access to clinicians trained in trauma informed care and other evidenced based practices.	Response demonstrates a very good understanding and proposes an approach that is innovative and will expand access to evidenced based approaches by working with NC organizations as evidenced by Table 36-2 on pages 334-335 of 784 pages in Offeror's response.					

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#	Aetna	AmeriHealth	BCBS	CCH	My Health by Health Providers	Optima	United HealthCare	WellCare
37.a	Exceeds		Sub Exceeds	Exceeds	Exceeds	Exceeds	Exceeds	
	Response demonstrates a very good understanding and proposes a comprehensive approach as evidenced by Table 37-1 on pages 485-486 of 817 in Offeror's response.		Response demonstrates a very good understanding and proposes an approach that is detailed and adds value as demonstrated in Offeror's response in Figure 37-1 (page 338 of 784) and Table 37-1 (pages 340-342 of 784).	Response demonstrates a very good understanding and proposes an approach that provides a clear and comprehensive plan for prevention and population health management programs. See Table A-1 Interventions that Span Our PPHM Programs .	Response demonstrates a very good understanding and proposes a comprehensive approach as evidenced by Exhibit 37-1 on pages 202-204 of 498 pages of response.	Response demonstrates a very good understanding and proposes an approach that provides a clear and comprehensive plan for member and provider interventions and expected outcomes. See Tables 37-1 – 37-6 for details.	Response demonstrates a very good understanding and has proposes an approach that provides comprehensive interventions for members, providers and system outcomes.	
37.b	Exceeds		Sub Exceeds					
	Response demonstrates a very good understanding and proposes an approach that demonstrates experience in NC at the state and regional levels through the NC Harm Reduction Coalition and CCNC's CPESN.		Response demonstrates an excellent understanding and proposes an approach that is detailed and adds value as demonstrated in Offeror's response as evidenced by Figure 37-2 (page 343 of 784) and Table 37-2 (page 346 of 784).					

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#	Aetna	AmeriHealth	BCBS	CCH	My Health by Health Providers	Optima	United HealthCare	WellCare
38.a			Exceeds		Exceeds			
			Response demonstrated a very good understanding and proposes a comprehensive approach demonstrating their experience based on past successful programs and the capacity to fully implement all requirements in a way that adds value to the Department. See Table 38-1 Blue Cross NC Identified Opportunities to Address Regional Challenges and Takes Action.		Response demonstrates a very good understanding and proposes a comprehensive approach to addressing unmet health related resource needs from a regional perspective as evidenced by Exhibit 38-1 on pages 212-213 of 498 in response.			
38.b								Exceeds
								Response demonstrates a very good understanding and proposes an approach that reflects knowledge and experience with local community-based

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#	Aetna	AmeriHealth	BCBS	CCH	My Health by Health Providers	Optima	United HealthCare	WellCare
								organizations. See Table 38-3 Key Partnerships to Address Unmet Health Related Resource Needs in North Carolina.
38.c			Exceeds	Exceeds			Exceeds	Exceeds
			Response demonstrated a very good understanding and proposes an approach that includes detailed strategies (housing instability, food insecurity, transportation, and interpersonal safety) for opportunities for health to fully meet and add value to the Department's requirements.	Response demonstrates a very good understanding and proposes an approach that provides a clear and comprehensive plan with strategies to address Key Opportunities for Health in the several domains. See Tables on pages 578 – 584 of 1109 for information detailing the approach.			Response demonstrates a very good understanding and proposes an approach that is comprehensive to address housing stability, [REDACTED]	Response demonstrates a very good understanding and proposes a comprehensive approach as evidenced by Table 38-3 "Key Partnerships To Address Unmet Health Related Resource Needs in North Carolina" on page 407 of 795 in Offeror's response.
40.a		Exceeds	Exceeds	Exceeds		Exceeds	Sub Exceeds	Sub Exceeds
		Demonstrates a very good understanding and proposes a comprehensive and detailed approach broken down by regions that includes having	Demonstrates a very good understanding and proposes an approach that includes a detailed process to efficiently establish an	Response demonstrates a very good understanding and proposes an approach that provides a detailed approach that supports		Demonstrates a very good understanding and proposes an approach that is innovative that includes the use of Quest Analytics	Demonstrates an excellent understanding and proposes a comprehensive detailed approach that includes extensive details on the LOIs with	Demonstrates an excellent understanding and proposes a comprehensive detailed approach that includes extensive details on the LOIs with

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#	Aetna	AmeriHealth	BCBS	CCH	My Health by Health Providers	Optima	United HealthCare	WellCare
		LOIs and LOAs with key Providers and dedicated staff for each contracted provider.	adequate and robust network, includes the road map platform prioritizing recruitment efforts, geo access and HQC patient monitoring. See Figure 40-1.	LOAs with hospital delivery systems and employed and affiliated provider practices, key children's hospitals, Indian health care providers and Cherokee Indian Hospital Authority. This includes agreements with providers in all six regions. See examples of Providers with Signed Agreements pages 592-593 and 593-594 Innovative Approaches to Network Development of 1109.		Suite and MD LIVE virtual platform.	key Providers, an established network with 20,000 existing Medicaid Providers, and leverages existing pharmacy network.	key Providers and an established network with existing Medicaid Providers. Table 40-1 on page 418 of 795 provides a detailed strategy for recruiting key providers.
40.b	Exceeds							Exceeds
	Demonstrates a very good understanding and proposes a comprehensive approach that includes details such as timelines to ensure limited network gaps and barriers. Timelines include weekly review of							Demonstrates a very good understanding and proposes a comprehensive approach that includes on-going monitoring and development of network providers, monthly GEOAccess, and

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#	Aetna	AmeriHealth	BCBS	CCH	My Health by Health Providers	Optima	United HealthCare	WellCare
	complaints to identify network gaps, annual panel studies, monthly provider directory audits, and monthly phone surveys.							outreach to noncontracted and out of state providers.
40.e			Exceeds			Exceeds		
			Demonstrates a very good understanding and proposes an approach that includes the Healthy Blue Medicaid Training Academy that incorporates a variety of delivery methods to provide information such as written, in-person, online and webinars to providers.			Demonstrates a very good understanding and proposes an approach that details various modes of training for new providers that includes on-site visits, targeted training, and identifies the topics for training.		
40.f								Exceeds
								Demonstrates a very good understanding and proposes an approach that includes a variety of software tools such as [REDACTED]

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#	Aetna	AmeriHealth	BCBS	CCH	My Health by Health Providers	Optima	United HealthCare	WellCare
40.g			Exceeds	Exceeds				
			Demonstrates a very good understanding and proposes a detailed approach as demonstrated in Table 40-1 on page 377-of 784 of Offeror response.	Response demonstrates a very good understanding of all expectations and proposes a detailed approach as evidenced on pages 602-604 of 1109.				
40.h			Exceeds					
			Demonstrates a very good understanding and proposes a detailed approach for recruitment that includes partnering with local organizations and universities, the use of physician extenders and expanding the health care workforce.					
40.i		Exceeds						
		Demonstrates a very good understanding and proposes an approach that develops an infrastructure to						

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#	Aetna	AmeriHealth	BCBS	CCH	My Health by Health Providers	Optima	United HealthCare	WellCare
		provide services to address the health needs through opportunities such as dispatching mobile units and providing financial assistance in order to support and sustain providers.						
40.j			Exceeds	Exceeds				Exceeds
			Demonstrates a very good understanding and proposes an approach that includes the development of access to care for children through relationships with key pediatric provider groups and school-based telemedicine programs.	Response demonstrates a very good understanding and proposes forward thinking approaches as demonstrated in the Pediatric Network Regional Highlights on page 606 of 1109.				Demonstrates a very good understanding and includes a detailed approach that actively recruits out of state border providers and includes a comprehensive directory that includes age ranges the provider services.
41.j	Exceeds						Exceeds	Exceeds
	Demonstrates a very good understanding and proposes an approach that is provider-friendly and includes a directory that is available on the website and mobile apps, is updated nightly,						Demonstrates a very good understanding and proposes an approach that includes an intense validation process that includes SMART/Targeted validation, data	Demonstrates a very good understanding and proposes an approach that provides a detailed strategy that includes a network integrity team, monthly telephone outreach,

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#	Aetna	AmeriHealth	BCBS	CCH	My Health by Health Providers	Optima	United HealthCare	WellCare
	includes a clear process for updating and adding information, and details search capabilities for providers.						analytics and data profiling.	quarterly reconciliation, and reconciliation with CAQH Proview, LexisNexis Provider Point, and CMS Death Master Files.
42.a	Sub Exceeds	Exceeds	Exceeds		Exceeds		Exceeds	Exceeds
	Demonstrates an excellent understanding and proposes an approach as evidenced by a robust provider portal (see Appendix K on pages 120-126 of page 126 of response), a strong training module for providers to include technical assistance and provider follow-up, and first-call resolution rates in more than one services area are statistically high.	Demonstrates a very good understanding and proposes a detailed approach that includes several options to support a portal that is clear and comprehensive to support providers.	Response demonstrates a very good understanding and proposes a detailed approach which includes a single sign-on multi-payee system and engaging the Healthy Blue Training Academy detailed in Figure 42-2 on page 401 of 784, and the Healthy Blue Providers Champions detailed on page 42-1 on page 400 of 784.		Demonstrates a very good understanding and proposes an approach that is comprehensive and includes a variety of support methods such as face to face, in person forums, and administrative and technical assistance at the provider's office.		Demonstrates a very good understanding and proposes a comprehensive approach that includes details such as provider relations and engagement, key functionality of the online portal and staffing for the provider transformation and behavioral health support teams.	Demonstrates a very good understanding and proposes a comprehensive approach that includes detailed staffing, multi-delivery methods for provider training and education, and a high-level training plan (Table 42-2).
43	Exceeds							
	The response demonstrates a very good understanding and proposes an							

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#	Aetna	AmeriHealth	BCBS	CCH	My Health by Health Providers	Optima	United HealthCare	WellCare
	approach that includes a detailed description of how the plan will meet provider payment requirements. Table 43-1 on page 554 of 817 provides details to support the approach. Figure 43-1 on page 557 of 817 illustrates a well-designed strategy for developing a volume to value continuum.							
44.a								Exceeds
								Demonstrates a very good understanding and proposes a detailed comprehensive approach that is fully compliant with NCQA, includes an automated reporting and data analytics systems and multiple sources for filing grievances. See Figure 44-2 on page 461 of 795.
44.b			Exceeds					

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#	Aetna	AmeriHealth	BCBS	CCH	My Health by Health Providers	Optima	United HealthCare	WellCare
			Response demonstrates a very good understanding and proposes an approach that includes newsletters, a provider quick reference card, and new provider orientation grievance and appeals excerpt.					
45		Exceeds	Exceeds				Sub Exceeds	Sub Exceeds
		Demonstrates a very good understanding and proposes an approach that includes clear and comprehensive QAPIs, details on the data and IT capabilities with a strong focus on successful experience with quality improvement.	Demonstrates a very good understanding and proposes an approach that includes innovative quality improvements especially in the areas of health disparities, provided an excellent breakdown of CAHPS, and very good data and analytic capabilities with AmeriGroup's experience.				Demonstrates an excellent understanding and proposes an approach that aligns [REDACTED]	The response demonstrates an exceptional understanding and proposes a comprehensive approach that details their experience with the ability to capture data related to unmet health and resource needs. Approach utilizes a quality performance metrics engine, hot spotting, and appointment agendas.
46		Exceeds	Exceeds				Exceeds	
		The response demonstrates a	The response demonstrates a				Demonstrates a very good	

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#	Aetna	AmeriHealth	BCBS	CCH	My Health by Health Providers	Optima	United HealthCare	WellCare
		very good understanding and proposes an approach that builds on successful experience with VBP arrangements in other states, includes a detailed 3-year plan to implement VBP in NC, and provide a PerformPlus value-based portfolio.	very good understanding and proposes an approach that builds [REDACTED] Department's requirements.				understanding of all expectations and proposes an approach that builds on their successful experience with [REDACTED]	
47							Exceeds	
							Response demonstrates a very good understanding and proposes a strategic approach that is based on their experience with members of other federally recognized tribes, and provides a detailed tribal	

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#	Aetna	AmeriHealth	BCBS	CCH	My Health by Health Providers	Optima	United HealthCare	WellCare
							engagement plan and timeline for engagement. See Figure 45 on page 625 of 862 for supporting information.	
48					Exceeds		Exceeds	Exceeds
					Response demonstrates a very good understanding and proposes an approach that includes details about stakeholder engagement strategies as evidenced by Exhibit 48-2 on page 306 of 498 in response, along with the draft Local Community Collaboration Strategy.		Response demonstrates a very good understanding and provides a strategic approach built upon their experience with the draft Local Community Collaboration Strategy.	Response demonstrates a very good understanding and provides a strategic approach that is detailed to fully meet expectations based on their experience with community and county organizations, and provides a robust community collaboration strategy to implement the Department's vision and goals.
50		Exceeds						
		Response demonstrates a very good understanding and proposes an approach that includes detailed						

Attachment #4 PHP Evaluation Committee Meeting Notes and Timeline

#	Aetna	AmeriHealth	BCBS	CCH	My Health by Health Providers	Optima	United HealthCare	WellCare
		information for the required service lines, such as live person access 24x7x365, single view of member information, all transfer calls are "warm transfers", and all services lines receive mental health first aid.						
51	Exceeds		Exceeds				Exceeds	Exceeds
	The response demonstrated a very good understanding and proposes an approach that includes a three-tiered training process, engages stakeholder approval of culturally sensitive material, provides multi-modal learning opportunities, and ADDIE training model.		Response demonstrates a very good understanding and proposes an approach that includes a variety of training methods and options as provided in Figure 51-2 on Page 485 of 784, and member/provider specific topics.				Response demonstrates a very good understanding and proposes a detailed approach that is comprehensive, member focused with [REDACTED]	Response demonstrates a very good understanding and proposes a detailed and comprehensive approach for training curriculum as evidenced in Table 51-1 on page 533 of 795.
52	Exceeds						Exceeds	
	Response demonstrates a very good understanding and proposes an approach that includes						Response demonstrates a very good understanding and proposes a detailed approach that includes a	

Attachment #4 PHP Evaluation Committee Meeting Notes and Timeline

#	Aetna	AmeriHealth	BCBS	CCH	My Health by Health Providers	Optima	United HealthCare	WellCare
	integration with CCNC system, analytics include several different software and reporting applications, reporting templates are extensive including their operating plan and QAPI.						comprehensive suite of data analytics, such as their SMART database platform, dedicated national support teams and a process to ensure accurate timely reporting.	
53	Exceeds							
	Response demonstrates a very good understanding and proposes a detailed approach that includes multilevel interdepartmental and committee review processes, includes staff responsibilities, impact review to adjacent policies and procedures, and incorporates an on-going review to update and modify where needed.							
54, Supporting Document ation - Draft Business					Exceeds			

Attachment #4 PHP Evaluation Committee Meeting Notes and Timeline

#	Aetna	AmeriHealth	BCBS	CCH	My Health by Health Providers	Optima	United HealthCare	WellCare
Continuity Plan								
					Response demonstrates a very good understanding of the requirements for continuity of operations as demonstrated in the draft Business Continuity Plan that includes [REDACTED]			
55								Exceeds
								The response demonstrates a very good understanding and proposes an approach that includes high touch provider education, a high adjudication rate, and a capacity model to support timely processing of claims.

Attachment #4 PHP Evaluation Committee Meeting Notes and Timeline

#	Aetna	AmeriHealth	BCBS	CCH	My Health by Health Providers	Optima	United HealthCare	WellCare
56.a, b, d	Exceeds						Exceeds	Exceeds
	The response demonstrates a very good understanding and proposes an approach that provides a detailed strategy to ensure complete, accurate and timely data which includes multiple front-end claim edits and a claim check code auditing solution.						Demonstrates a very good understanding and proposes an approach that includes a detailed EDS inbound process as illustrated in Figure 51 and the accompanying table on pages 674-675 of 862; demonstrates capability and experience with drug rebates and diagnosis code capture.	Response demonstrates a very good understanding and proposes a detailed and comprehensive approach with regards to system configurability, oversight and provider education. Also, includes detailed information on encounter drug rebates and risk adjustment.
56.c, e, f								Exceeds
								Response demonstrates a very good understanding and proposes an approach that proactively monitors claims and submission rates, and educates and assists providers on root-cause and remediation. Also includes several examples of leading practices to improve data quality.

Attachment #4 PHP Evaluation Committee Meeting Notes and Timeline

#	Aetna	AmeriHealth	BCBS	CCH	My Health by Health Providers	Optima	United HealthCare	WellCare
56.g				Exceeds				Exceeds
				The response demonstrates a very good understanding and proposes an approach that details the process for managing denied claims submissions, submission of duplicate claims, and reconciliation of zero-pay encounter submissions.				Response demonstrates a very good understanding and proposes an approach that includes detailed understanding of the challenges such as duplicate encounter submissions/rejections, capitated/subcapitated claims and value-based arrangements.
60							Exceeds	Exceeds
							Response demonstrates a very good understanding and proposes a detailed and comprehensive approach as evidenced by the Draft Compliance Plan which describes key elements of compliance, outlines United's principles of ethics and integrity, and includes employee engagement.	The response demonstrates a very good understanding and proposes a comprehensive program being evaluated annually, is governance driven, includes details on compliance roles and security issues education, and has a compliance certification program.

Attachment #4 PHP Evaluation Committee Meeting Notes and Timeline

#	Aetna	AmeriHealth	BCBS	CCH	My Health by Health Providers	Optima	United HealthCare	WellCare
62	Exceeds	Exceeds					Exceeds	Exceeds
	Response demonstrates a very good understanding and proposes an approach that includes technology tools, a robust investigative process, and monitoring for audit and pharmacy claims. The draft Fraud, Waste and Abuse Prevention Plan provides supporting documentation that demonstrates their ability to operationalize the approach.	Response demonstrates a very good understanding and proposes an approach that includes a detailed data mining process, addresses members, provider and pharmacy issues, and provides a detailed draft plan that outlines the policies. See Figure 62-2 on page 382 of 524 for supporting information.					Response demonstrates a very good understanding and proposes a comprehensive approach which includes the Prospective 2.0 Scoring tool, the detailed Fraud, Waste and Abuse Plan, and proactive strategies to balance tension between providers and their FWA responsibilities.	Response demonstrates a very good understanding and proposes an approach that includes a detailed and comprehensive draft fraud, waste and abuse plan, different technologies to support data mining efforts, and an in-depth view of how they will implement their approach.
62.5	Exceeds							
	The response demonstrates a very good understanding and proposes an approach that is clear and supported by detailed information to identify Aetna's end-to-end COB identification and recovery process							

Attachment #4 PHP Evaluation Committee Meeting Notes and Timeline

#	Aetna	AmeriHealth	BCBS	CCH	My Health by Health Providers	Optima	United HealthCare	WellCare
	as evidenced by Figure 62.5-1 TPL Identification and Recovery on page 736 of 817.							
64	Exceeds			Exceeds				
	Response demonstrates a very good understanding and proposes a comprehensive approach as evidenced by their robust administrative and staff safeguards, and a high level of Risk Analysis and security program compliance.			The response demonstrates a very good understanding and proposes a detailed and comprehensive approach as evidenced by their increased focus on innovative and secure technologies, including parameter driven tools/utilities along with a robust Data Recovery and backup capability.				
65	Exceeds							Exceeds
	Response demonstrates a very good understanding and proposes a detailed and comprehensive approach as evidenced by their extensive and hardened Network and							Response demonstrates a very good understanding and proposes a detailed approach as evidenced by their innovative solution that automates their transition of care process as shown

Attachment #4 PHP Evaluation Committee Meeting Notes and Timeline

#	Aetna	AmeriHealth	BCBS	CCH	My Health by Health Providers	Optima	United HealthCare	WellCare
	telecommunications infrastructure and a comprehensive root cause analysis program.							in Figure 65-1 on page 627 of 795.
Use Case Scenario #1								Exceeds
								The response demonstrates a very good understanding and outlines their approach to multidisciplinary care management for complex care needs. Includes a lead care manager for both Emily and Timothy, an understanding of social determinates per Table 1.1 of response, a focus on family preservation, and the substance abuse treatment and approach needs.
Use Case Scenario #2		Exceeds						
		Response demonstrates a very good understanding and						

Attachment #4 PHP Evaluation Committee Meeting Notes and Timeline

#	Aetna	AmeriHealth	BCBS	CCH	My Health by Health Providers	Optima	United HealthCare	WellCare
		provides a comprehensive approach that articulates the connection between care management, social determinates, housing and community engagement.						
Use Case Scenario #4					Exceeds			
					Response demonstrates a very good understanding and provides a comprehensive approach to addressing the unmet health related needs as evidenced by Exhibit UCS-4 on page 430 of 498 of Offeror's response.			
Use Case Scenario #6							Exceeds	
							Demonstrates a very good understanding as the response outlines the various programs and services by having a	

Attachment #4 PHP Evaluation Committee Meeting Notes and Timeline

#	Aetna	AmeriHealth	BCBS	CCH	My Health by Health Providers	Optima	United HealthCare	WellCare
Use Case Scenario #7			Exceeds				Exceeds	
			Response demonstrates a very good understanding and provides a comprehensive approach detailing a timeline for				Response demonstrates a very good understanding and provides a comprehensive approach that included several scenarios for	

Respondent's Memorandum in Opposition to
Aetna Better Health of North Carolina, Inc.'s
Motion and Memorandum for Leave to Amend
its Petition for a Contested Hearing

Exhibit 1

**Affidavit of Kimberley Rene
Kilgore-Kilpatrick
(Part 2 of 2)**

Exhibit E

RFP #30-190029-DHB - Prepaid Health Plans

Highest Scoring Offer, Ranked 1st					736.19304		71.824%	
					Difference vs Ranked			
Type of Contract	Rank	Offeror Name	Weighted Total Score	Percentage of Total Possible Points	# Points	% Points		
Statewide	1		736.19304	71.824%	0.00000	0.00000%		
Statewide	2		727.76474	71.001%	-8.42830	-11.62500%		
Statewide	3		712.22431	69.485%	-23.96873	-32.40000%		
Statewide	4		706.66204	68.943%	-29.53100	-40.00000%		
Statewide	5		704.60144	68.742%	-31.59160	-42.50000%		
Statewide	6		629.71280	61.435%	-106.48024	-144.87500%		
Either	7		628.39969	61.307%	-107.79335	-146.25000%		
Regional	8		573.48539	55.950%	-162.70765	-220.00000%		

Total Possible Score 1025.00000
Total Possible If All Scores Meet Expectations (60%) 615.00000

Offeror is a PLE
Offeror did not achieve average score of Meets

RFP #30-190029-DHB - Prepaid Health Plans

Highest Scoring Offer, Ranked 1st	736.19304	71.824%
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Difference vs Ranked 1st

Type of Contract	Rank	Offeror Name	Weighted Total Score	Percentage of Total Possible Points	# Points	% Points
Statewide	1	WellCare Health Plans	736.19304	71.824%	0.00000	0.000
Statewide	2	United Health Care	727.76474	71.001%	-8.42830	-0.822
Statewide	3	BCBSNC – Healthy Blue	712.22431	69.485%	-23.96873	-2.338
Statewide	4	AmeriHealth Caritas North Carolina	706.66204	68.943%	-29.53100	-2.881
Statewide	5	Aetna	704.60144	68.742%	-31.59160	-3.082
Statewide	6	My Health by Health Providers	629.71280	61.435%	-106.48024	-10.388
Either	7	Carolina Complete Health	628.39969	61.307%	-107.79335	-10.516
Regional	8	Optima Health	573.48539	55.950%	-162.70765	-15.874

Total Possible Score 1025.00000
Total Possible If All Scores Meet Expectations (60%) 615.00000

Offeror is a PLE

Offeror did not achieve average score of Meets

RFP #30-190029-DHB - Prepaid Health Plans

Offeror Name	Aetna	AmeriHealth Caritas North Carolina	BCBSNC – Healthy Blue	Carolina Complete Health	My Health My Choice
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Proposal Evaluation Sub Criteria from Section II. Table 3	Attachment O: Offeror's Proposal and Response Section 3 Evaluation Questions Section	Proposal Evaluation Criteria Weights from Section II. Table 3	Proposal Evaluation Sub Criteria Sub Weights for Scope of Services from Section II. Table 3	Weighting for Evaluation Question Sections	Maximum Available Points per Section	Evaluation Question #	Weighted Score	Weighted Score	Weighted Score	Weighted Score	Weighted Score
	Offeror Qualifications & Experience	20%			200.00000	1 - 10	172.82500	164.72923	157.08500	126.85500	155.80000
a) Develop, implement and sustain the organizational, operational, technical and administrative functions and capabilities to reliably serve as an effective partner in delivering Medicaid Managed Care to North Carolinians. b) Improve the likelihood of better health outcomes by enhancing the Member experience through promoting Member rights, engaging Members through health education, providing optimal customer service and support, and delivering services in a culturally competent manner. c) Develop coordinated programs and services that deliver health through whole-person care, comprehensive care management, improve population health, and provide programs and services addressing healthy opportunities. d) Develop and maintain a robust provider network that maintains strong provider and community participation and demonstrates an understanding of the health needs of the North Carolina population to ensure available, accessible, high quality care and services are delivered to all Members. e) Develop a comprehensive quality improvement and value-based purchasing approach to drive the Department's overall vision for advancing and measuring high-value care. f) Engage and integrate key Department partners and stakeholders including tribal populations, county agencies, community-based organizations, other managed care program entities, and Department partners to support North Carolina's Medicaid Managed Care goals. g) Promote and monitor North Carolina's Medicaid Managed Care sustainability by developing the processes, standards, and data protocols needed to demonstrate good financial stewardship of limited resources and adherence to financial management objectives. h) Promote a culture of compliance through comprehensive oversight and program integrity strategies aligned with industry best practices and compliant with federal and state law and regulation.	Administration & Management Program Operations	70%	7.5%	50.0%	28.25000	12 - 19	17.94844	17.62031	19.26094	15.09375	16.80000
				25.0%	13.12500	50 - 54	9.05625	9.18750	8.53125	7.87500	7.60417
	Other			25.0%	13.12500	64 - 65	11.16625	7.87500	7.87500	8.95781	7.87500
	Members	70%	15%		105.00000	20 - 24	67.65938	62.31750	68.23688	70.08750	62.89583
	Benefits & Care Management			25%	175.00000	25 - 39	116.48000	110.12750	120.41750	99.38250	107.91667
	Providers			15%	105.00000	40 - 44	70.61250	66.15000	69.01125	65.10000	61.26667
	Quality & Value			15%	105.00000	45 - 46	63.00000	89.25000	89.25000	63.00000	50.40000
	Stakeholder Engagement			7.5%	52.50000	47 - 49	31.50000	31.50000	31.50000	31.50000	32.41667
	Claims and Encounter Management Financial Requirements			10%	35.00000	55 - 56	21.05863	21.00000	17.95150	22.46563	19.35833
				50%	35.00000	57 - 59	20.05500	20.05500	21.63000	19.58250	21.63000
	Compliance			5%	35.00000	60 - 63	24.50000	22.75000	21.00000	21.00000	21.00000
	Use Cases	5%			50.00000	Scenarios #1 - #7	30.00000	30.35000	30.47500	30.00000	27.25000
	Client References	5%			50.00000	Client References #1 - #4	48.75000	48.75000	25.00000	42.50000	37.50000
	Subtotal Score	100%	100%		1000.00000		704.60144	701.66204	687.22431	623.39969	629.71667
	Bonus Points	2.5%			25.00000	11	0.00000	5.00000	25.00000	5.00000	0.00000
	Total Score	102.5%			1025.00000		704.60144	706.66204	712.22431	628.39969	629.71667

	Partner Entity 1	Partner Entity 2	Partner Entity 3	Partner Entity 4	Partner Entity 5	Partner Entity 6	Partner Entity 7	Partner Entity 8	Partner Entity 9	Partner Entity 10	Partner Entity 11	Partner Entity 12	Partner Entity 13	Partner Entity 14	Partner Entity 15	Partner Entity 16	Partner Entity 17	Partner Entity 18	Partner Entity 19	Partner Entity 20	Partner Entity 21
	Aetna Med/Led Administrators LLC	Aetna Health Management LLC	Cardmark/PCS Health LLC	Community Care of North Carolina, Inc.	Enclave Healthcare MSJ, LLC	One Call Root Solutions, LLC	Aetna Partners	Superior Vision	Enter Entity Name Here	Enter Entity Name Here	Enter Entity Name Here	Enter Entity Name Here	Enter Entity Name Here	Enter Entity Name Here	Enter Entity Name Here	Enter Entity Name Here	Enter Entity Name Here	Enter Entity Name Here	Enter Entity Name Here	Enter Entity Name Here	Enter Entity Name Here
Enter Experience Rating Here	Meets	Meets	Exceeds	Exceeds	Exceeds	Exceeds	Meets	Exceeds													
Enter Integration Rating Here	Meets	Meets	Meets	Exceeds	Meets	Meets	Meets	Meets													
Enter Comments for Experience Rating			40 million in claims for Aetna experience since 1975; robust approach to service delivery	20 million in H-C Medicaid; proven Data Analysts	Currently utilized in 12 states; extensive based clinical question for informed decisions	30 yrs experience; over 1 million calls nationwide in 2017		7 million Medicaid Members in 15 states and Washington, DC; 25 years of experience													
Enter Comments for Integration Rating				Community based approach and fully integrated function																	

Proposal Evaluation Criteria from Section 8, Table 3	Proposal Evaluation Sub-Criteria from Section 8, Table 3	Attachment G: Officer's Proposal and Response Section 3 Evaluation Questions Section	Proposal Evaluation Sub-Criteria Weights from Section 8, Table 3	Proposal Evaluation Sub-Criteria Sub-Weights from Section 8, Table 3	Weighting for Evaluation Questions Section	Maximum Available Points per Question Section	Question Weights	Question Sub-Weights	Maximum Available Points per Question	Evaluation Question #	Evaluation Question	Evaluation Question Sub-Component	Consensus Score	Officer's Weighted Score	Scoring Guide	Comments	Scoring Options
								15%	5.25000		B. Experience and approach to providing evidence for decision services, including special needs of treatment.	Exceeds		4.46250	Use the Scoring guide	The response demonstrates a very good understanding of expectations and proposes an approach that includes the use of a community pharmacy enhanced network, a detailed approach on alignment with action plan and a well-defined, tested strategy. (See Table 25.2.)	Automatically Exceeds Exceeds Meets Partially Meets Does Not Meet
								25%	0.75000		C. Experience with innovative telemedicine modalities and plan to integrate telemedicine into the proposed telemedicine approach to encourage use of telemedicine, including type of program, and	Meets		5.25000	Use the Scoring guide		Automatically Exceeds Exceeds Meets Partially Meets
								15%	3.50000		D. Experience with and expertise for implementation of care and services (i.e. dental services, LBN, CPOKs, caregivers).	Partially Meets		1.40000	Use the Scoring guide	Response demonstrates that the Officer has a fair understanding of the expectations and proposes an approach that will certainly address the correct connection between FFS and managed care will be implemented with relation to carved-out services. Specifically, the approach does not meet the expectations for the coordination of FFS and managed care services. (See Section V.C.1.B. and Table C.1.1 of the RFP.)	Automatically Exceeds Exceeds Meets Partially Meets Does Not Meet
							8%	50%	7.00000	26	The Officer shall comply to achieve and describe the approach to meeting the Department's Utilization Management (UM) and requirements outlined in Section V.C.1. Medical and Behavioral Health Management. The Officer shall include:	Meets		4.20000	Use the Scoring guide		Automatically Exceeds Exceeds Meets Partially Meets
								15%	2.10000		B. Proposed evidence-based decision support tool.	Meets		1.26000	Use the Scoring guide		Automatically Exceeds Exceeds Meets Partially Meets
								5%	0.70000		C. Approach to reduce or provide administrative burden for the FFS, UM Program including, but not limited to, provide experience for prior authorization requests.	Meets		0.42000	Use the Scoring guide		Automatically Exceeds Exceeds Meets Partially Meets
								10%	1.40000		E. Evidence and approach to reduce member access to care for members with the administration of the UM Program.	Meets		0.56000	Use the Scoring guide		Automatically Exceeds Exceeds Meets Partially Meets
								10%	1.40000		F. Approach to integrate medical and behavioral health services in the UM program.	Meets		0.56000	Use the Scoring guide		Automatically Exceeds Exceeds Meets Partially Meets
								6%	0.70000		F. Risk, educational health assessment in the Officer's UM Program and	Meets		0.42000	Use the Scoring guide		Automatically Exceeds Exceeds Meets Partially Meets
								5%	0.70000		G. Approach to ensure UM Program compliant with	Meets		0.42000	Use the Scoring guide		Automatically Exceeds Exceeds Meets Partially Meets
							10%	40%	7.00000	27	The Officer shall describe the LOS and value-based services in the Officer's proposed UM Program for approval. The response shall include:	Meets Not Provided			Decision to be made by the Officer only. Response not required.		
								25%	4.37500	28	The Officer shall comply to achieve and describe the approach to meeting the Department's Utilization Management (UM) and requirements outlined in Section V.C.1. Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program.	Meets		4.20000	Use the Scoring guide		Automatically Exceeds Exceeds Meets Partially Meets
								25%	4.37500		C. Description of medical necessity review process, including examples of how the Officer has applied the process to a member (in or out of town) (2) approved services and	Meets		2.62500	Use the Scoring guide		Automatically Exceeds Exceeds Meets Partially Meets
								10%	1.75000		D. Covered services to member Members (screened membership and provider services).	Meets		2.62500	Use the Scoring guide		Automatically Exceeds Exceeds Meets Partially Meets
										EPSCS SUPPORTING DOCUMENTATION and	Meets		1.05000	Use the Scoring guide		Automatically Exceeds Exceeds Meets Partially Meets	
							8%	50%	7.00000	29	The Officer shall comply to achieve and describe the approach to meeting the Department's Utilization Management (UM) and requirements outlined in Section V.C.2. Pharmacy Services. The Officer shall include:	Meets		4.20000	Use the Scoring guide		Automatically Exceeds Exceeds Meets Partially Meets
								15%	2.10000		B. Approach to engage members in understanding the pharmacy benefit and to provide medication-related clinical services which include appropriate medication use and adherence.	Exceeds		1.75000	Use the Scoring guide	Response demonstrates a very good understanding of all expectations and proposes a comprehensive care management focus outlined in Table 29-2 on pages 415-416 of 517 in Officer's RFP table.	Automatically Exceeds Exceeds Meets Partially Meets Does Not Meet
								10%	1.40000		C. Prior authorization process, including, but not limited to, provide experience when requesting prior authorization.	Meets		0.68000	Use the Scoring guide		Automatically Exceeds Exceeds Meets Partially Meets
								6%	0.70000		D. Transition response and provisions to ensure access to medications during a state of emergency or disaster.	Meets		0.42000	Use the Scoring guide		Automatically Exceeds Exceeds Meets Partially Meets
								10%	1.40000		E. Program approval with PBM (if applicable).	Exceeds		1.19000	Use the Scoring guide	Response demonstrates a very good understanding of all expectations and proposes an approach that includes a well-coordinated integration outlining specific roles and responsibilities outlined in Table 29-3 on pages 417 of 517 in Officer's RFP table.	Automatically Exceeds Exceeds Meets Partially Meets Does Not Meet
								10%	1.40000		F. Approach to provide timely, accurate and complete	Meets		0.68000	Use the Scoring guide		Automatically Exceeds Exceeds Meets Partially Meets
							7%	50%	6.12000	30	The Officer shall comply to achieve and describe the approach to meeting the Department's Utilization Management (UM) and requirements outlined in Section V.C.4. Transition of Care. The Officer shall include:	Meets		3.67500	Use the Scoring guide		Automatically Exceeds Exceeds Meets Partially Meets
								50%	6.12000		B. Officer's staff Provider Transition of Care Policy	Meets		3.67500	Use the Scoring guide		Automatically Exceeds Exceeds Meets Partially Meets
							4%	40%	2.60000	31	The Officer shall comply to achieve and describe the approach to meeting the Department's Utilization Management (UM) and requirements outlined in Section V.C.5. Non-Emergency Medical Transportation. The Officer shall include:	Meets		1.60000	Use the Scoring guide		Automatically Exceeds Exceeds Meets Partially Meets

Company Name and Address	Contact Information	Summary of services/relevance to scope of RFP
[REDACTED]	[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]	[REDACTED]

Minimum Qualifications Table

[illegible][illegible]

	Partner Entity 1	Partner Entity 2	Partner Entity 3	Partner Entity 4	Partner Entity 5	Partner Entity 6	Partner Entity 7	Partner Entity 8	Partner Entity 9	Partner Entity 10	Partner Entity 11	Partner Entity 12	Partner Entity 13	Partner Entity 14	Partner Entity 15	Partner Entity 16	Partner Entity 17	Partner Entity 18	Partner Entity 19	Partner Entity 20	Partner Entity 21	Partner Entity 22	Partner Entity 23
	Affinity Behavioral Healthcare	AmeriHealth Caritas Services, LLC	Ascus Third Party Administrators Inc.	Cadence	Cadence	Discovery Health Partners	Health Management Systems	LogistiCare	National Imaging Associates	OmniHealth Solutions	Perform Rx	Source HOF/Health	Tillman Health Resources	Vaya Health	Enter Entity Name Here	Enter Entity Name Here	Enter Entity Name Here	Enter Entity Name Here	Enter Entity Name Here	Enter Entity Name Here	Enter Entity Name Here	Enter Entity Name Here	Enter Entity Name Here
Star Performance Rating, Inc.	Overall	Med	Substantially Exceed	Overall	Med	Overall	Overall	Substantially Exceed	Overall	Overall	Overall	Overall	Overall	Overall									
Star Hospital Rating New	Overall	Med	Med	Med	Med	Med	Med	Overall	Med	Overall	Med	Overall	Overall	Overall									
Star Composite for Performance Rating	225,000 Medicaid patients; performance metrics		15yrs experience, 3 million claims, accuracy rate of over 99%	worked with 60 plus care organizations; 1.4 billion savings due to identified potential in 2022		40 plus state Medicaid agencies supported virtually health plans since 2011	22 plus years of Medicaid experience; served 40 states; 24 million lives in 2017	20 years of Medicaid experience; high satisfaction rates	20 years of Medicaid experience; served 8 million lives	19 years in 14 states; Currently contracted with 70% of pharmacies in NC	Serving more than 60 Health Care Plans; 30 years of experience	225,000 Medicaid members; performance metrics	162,000 Medicaid members; performance metrics										
Star Composite for Hospital Rating	Multiple paths to access mental health first aid training					No vetting done across Regional transportation coordination	Proactive Knowled approach, coordinates with Primary Care Providers		Multiple Paths to access Mental Health First Aid training	Multiple paths to access	Multiple paths to access Mental Health First Aid training												

[illegible]

Company Name and Address	Contact Information	Summary of services/relevance to scope of RFP
Delaware Department of Health and Social Services, Division of Medicaid and Medical Assistance	Callisto.Bouillon-Buon@state.de.us , 302-255-9927	Managing Medicaid Managed Care, Processing and Paying Claims, Provider Network Management, Assuming Risk through Capitalized Contracts Performing Care Management Functions
Louisiana Department of Health	Jan.Shafer@lsu.gov , 225-342-2428	Managing Medicaid Managed Care, Processing and Paying Claims, Provider Network Management, Assuming Risk through Capitalized Contracts Performing Care Management Functions
Michigan Department of Health and Human Services	Jeffrey.McIntosh@mi.gov , 517-364-1126	Managing Medicaid Managed Care, Processing and Paying Claims, Provider Network Management, Assuming Risk through Capitalized Contracts Performing Care Management Functions
South Carolina Department of Health and Human Services	jamie.boudreau@sc.gov , 803-886-0444	Managing Medicaid Managed Care, Processing and Paying Claims, Provider Network Management, Assuming Risk through Capitalized Contracts Performing Care Management Functions

	Partner Entity 1	Partner Entity 2	Partner Entity 3	Partner Entity 4	Partner Entity 5	Partner Entity 6	Partner Entity 7	Partner Entity 8	Partner Entity 9	Partner Entity 10	Partner Entity 11	Partner Entity 12	Partner Entity 13	Partner Entity 14	Partner Entity 15	Partner Entity 16	Partner Entity 17	Partner Entity 18	Partner Entity 19	Partner Entity 20	Partner Entity 21
	BCBS NC	Amerigroup Partnership Plan, LLC	Amerigroup Corporation	ExcellMed/Vision Care, LLC	LogiCare Solutions, LLC	Ingenix, Inc.		CareMore Medical Group of Tennessee	CareMore Medical Associates	Enter Entity Name Here	Enter Entity Name Here	Enter Entity Name Here	Enter Entity Name Here	Enter Entity Name Here	Enter Entity Name Here	Enter Entity Name Here	Enter Entity Name Here	Enter Entity Name Here	Enter Entity Name Here	Enter Entity Name Here	Enter Entity Name Here
Enter Experience Rating Here	Substantially Benefits Here	None	Benefits	Benefits	Substantially Benefits	Benefits		None	None												
Enter Reimbursement Rating Here	None	None	None	Benefits	Benefits	None		None	None												
Enter Contracts Re Experience Rating	3.8 million members, largest health care insurer in all 100 counties, significant state experience		22 states and 159k, 6.4 million members	150,000 Medicaid members in 4 states, strong presence in NC with State Health Plan	22 plus years experience, 41 states, 26 million coverholders	24 years experience, pharmacy benefits in 17 states															
Enter Contracts Re Integration Rating				Deploying mobile solutions, we integrated into the Inc. marketplace, current partnership with HCBUS	No wrong door access, regional transportation coordination																

Copy of Attachment #11 PHP Consensus Scoring Excel File test.xlsx

Company Name and Address	Contact Information	Summary of services relevant to scope of RFP
Maryland Department of Health	JL.Casberg@maryland.gov 410-763-6449	Managing Medicaid Managed Care, Processing and Paying Claims, Provider Network Management, Assuming Risk through Capitated Contracts, Performing Care Management Functions
Georgia Department of Community Health	John.Bolmes@dcch.ga.gov	Managing Medicaid Managed Care, Processing and Paying Claims, Provider Network Management, Assuming Risk through Capitated Contracts, Performing Care Management Functions
BlueChoice Health Plan of South Carolina, Inc.	Jim.Vanorteg@bluechoice.com 803-724-9393	Managing Medicaid Managed Care, Processing and Paying Claims, Provider Network Management, Assuming Risk through Capitated Contracts, Performing Care Management Functions
Washington Health Care Authority	casbertn@chca.wa.gov 206-775-1786	Managing Medicaid Managed Care, Processing and Paying Claims, Provider Network Management, Assuming Risk through Capitated Contracts, Performing Care Management Functions

Exhibit F

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5. Offeror's Client References

The Offeror must provide four (4) client references for which it has provided services of similar size and scope to that requested herein. The Department prefers at least three (3) references from state Medicaid programs. If three (3) state Medicaid programs are not provided, Offeror must include a statement explaining why. The Department may take this into consideration when scoring the Offeror's Client References.

The Offeror must complete the reference table below for each client reference, and sign the bottom of this Form to include in its proposal. The Offeror should indicate in the Offeror Name field the actual organization that held the contract with the submitted client reference (e.g., the Offeror, one of the Offeror's subcontractors, joint venture partner) and state the relationship to the Offeror if applicable. The Offeror shall ensure that the Contact Person listed in the table is qualified and well-versed to elaborate and verify the information provided by the Offeror. The Department may contact these clients to determine the services provided are substantially similar in scope to those proposed herein, and that Offeror's performance has been satisfactory. The information obtained in this attachment and obtained from the client will be considered in the evaluation of the offer. **The Department will not accept Department of Health and Human Services' employees as references.**

Offeror Name	Amerigroup Partnership Plan, LLC subcontract with BlueChoice Health Plan of South Carolina, Inc. (Amerigroup Partnership Plan) Relationship to Offeror: Subcontractor		
Contract Name	Healthy Connections	Contact Person Name	Tim Vaughn
Name of Client	BlueChoice Health Plan of South Carolina, Inc. (BlueChoice of SC)	Contact Person Title	President
Annual Contract Value	REDACTED	Contact Person Telephone Number	(803) 264-3364
Contract Start Date	Current: 7/1/2018 Original: 6/1/2008	Contact Person Email Address	<u>TIM.VAUGHN@bcbsc.com</u>
Contract End Date	6/30/2021	Geographic Area Served Under the Contract (e.g., Statewide, Regional)	Statewide
Scope of Services Provided Under Contract Listed Above (indicate Yes and number of staff assigned for all that apply)			

Managing Medicaid Managed Care beneficiary lives	Yes 3	Processing and paying claims	Yes 9
Provider network management	Yes 11	Assuming risk through capitated contracts	Yes 72 Health Plan and 20 shared services
Performing care management functions	Yes 43 staff	Other [Please describe]	Yes 26 staff in operations, quality marketing
Please describe the services provided under the contract listed above for each part answered "Yes" in Scope of Services Provided Under Contract Listed Above section.			
<p><u>Managing Medicaid Managed Care Beneficiary Lives</u></p> <p>Services provided to TANF, ABD, and uninsured adults include the following:</p> <ul style="list-style-type: none"> Physical health Behavioral health Service coordination Long-term care Vision Pharmacy services <p><u>Provider Network Management</u></p> <p>Services provided include the entire network management process:</p> <ul style="list-style-type: none"> Network provider identification, recruitment, and development including providers with trauma-informed care training Contracting and credentialing/recredentialing Orientation, initial, and ongoing training Technical support Ongoing monitoring of network adequacy and support for quality and Value-Based Payment (VBP) programs <p><u>Care Management Functions</u></p> <p>Services provided include:</p> <ul style="list-style-type: none"> Predictive modeling and risk stratification Initial and ongoing Care Needs Screening Comprehensive assessment/reassessment as needed and annually Developing, revising, and monitoring of the person-centered Member Care Plan including integration of other available treatment plans Coordination of services, supports, and community-based resources Consultation through multidisciplinary case rounds Monitoring performance against standards and requirements <p><u>Processing and paying claims</u></p> <p>Services provided include end-to-end processes such as:</p> <ul style="list-style-type: none"> Claims intake (electronic and paper) 			

- Front-end editing/validation, adjudication, provider payment and remittance advice (electronic and paper)
- Quality auditing
- Managing/monitoring claims operations against performance standards

Assuming Risk Through Capitated Contracts

Amerigroup Partnership Plan has provided services in South Carolina for over 10 years. Staffing has been adjusted over this timeframe to accommodate state and client needs, such as changes in program requirements and membership. Amerigroup currently has 72 employees supplemented by 20 FTEs provided by national shared services teams dedicated to operations. Staffing levels throughout the term of the contract may be adjusted based on changes in program requirements and membership.

An integral part of the staffing plan is to hire local staff, at the necessary level and with the appropriate experience, to provide the highest quality services to Members and providers and supplement them with designated and dedicated national support services to leverage national best practices and economies of scale. The health plan makes sure staffing levels comply and exceed state requirements and continually reviews staffing numbers against quality and service standards to determine whether additional employees are needed to adequately provide the Member-centered care management and comprehensive provider support. Each manager and department routinely reviews their specific responsibilities and determines whether sufficient numbers of employees are committed to the department to meet staffing needs. The health plan reviews changes in membership volume, covered services and service areas, and general changes in operations on an ongoing basis and staffing adjusted whenever necessary.

Other

Other functional areas supported by Amerigroup include, but are not limited to, operations and quality marketing.

Please indicate the number of covered lives under contract listed above.

96,337

Please indicate the number of Practitioners and Providers in your network under contract listed above.

Provider Type	Unique Providers
Family Practice	1,436
Pediatrics	821
OB/GYN	470
Geriatrics	15
Primary care	3,986
Specialty Providers	6,841
Certified Registered Nurse Anesthetists, Nurse Practitioners, Physicians Assistants	3,796
Ancillary	2,066
Total	16,689

Please describe any key strategies or innovative approaches executed (e.g., system of care, staff, operations, technology, and relationship management) to advance high-value care, financial innovations or increase operational efficiency under contract listed above.

Improving Well-child Visits for Infants in South Carolina

Amerigroup Partnership Plan launched a multi-year QAPI process to increase compliance with well-child visits completed in the first 15 months of life — a process that began in 2013 and continues today. Timely preventive care for children is a high priority in South Carolina where children are approximately 70% of the Medicaid population. The plan uses a three-pronged approach representing Member, data, and provider-oriented strategies and closely monitors HEDIS® trends using the NCQA Quality Compass tool to exceed the state-defined target of the regional 50th percentile. To achieve their Quality Improvement (QI) goals, the health plan's quality team works closely with HEDIS data managers through weekly meetings and ongoing review of gap-in-care reports to drive outreach initiatives and other interventions.

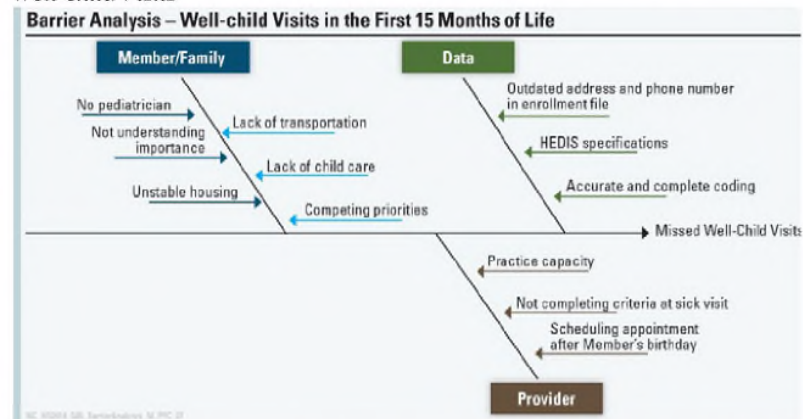
The health plan supports Member outreach activities through valid data resources and strategic collaborations with provider practices. The health plan monitors interventions and evaluates impact using well-tested QI techniques such as fishbone diagramming, as illustrated in Figure O.5-1, and a rapid-cycle improvement methodology to test QI interventions.

Findings are evaluated quarterly through the Quality Management Committee (QMC) processes, and guide new strategies over time with the goal of driving

continued improvement. The following list summarizes examples of key, implemented initiatives; these strategies have evolved over time to incorporate new and revised approaches to optimize Member engagement in well-child visits:

- Member-oriented strategies:
 - Clinic Days began in 2015 and have been continually refined to reach more Members. The plan now collaborates with large provider offices to benefit more children.
 - Live outbound calls to Member and families began in 2015; in 2017, the health plan improved targeting so a single household did not receive separate calls for each child who was a Member, and in 2018, these were supplemented with interactive voice response reminder calls.
 - In 2015, the plan initiated a special focus on timely maternity and postpartum care as an avenue to support early and comprehensive Member education that emphasizes the schedule for and importance of post-natal, infant, and well-baby care visits.
 - Member incentives were implemented in 2017 using gift cards to reward Members for participating in appointments; in 2018, the plan transitioned to reloadable cards.
 - After showing limited evidence of engaging Members, birthday reminder letters were discontinued at the end of 2017.
 - HealthCrowd text messaging providing well-child visit reminders began in 2018.
- Data-oriented strategies:

Figure O.5-1. Fishbone Diagram Visually Displays Root Causes of Missed Well-child Visits



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- Gap-in-care reports began in 2015 and continue to this day. Interventions used to address the gaps continue to be refined with the goal of reaching more Members — for example, in 2018 the health plan marketing team began to use gap-in-care report data to pinpoint “prime” locations for community outreach events.
- LexisNexis MemberPoint[®], introduced in 2018, provides supplemental Member contact information in response to a significant barrier of outdated enrollment information.
- **Provider-oriented Strategies**
 - The health plan distributes monthly gap-in-care reports electronically to providers. For “VIP” practices with more than 200 attributed Members, Practice Consultants from the Quality Management (QM) or Provider Relations team hand-deliver quality reports and review the information with office staff and coach them on quality improvement techniques.
 - Provider-focused education and training on quality enhancement, such as using HEDIS booklets and other resources to help provider offices understand critical timelines, how to accurately code for visits, and strategies to close gaps in care — coupled with financial rewards to incentivize their assistance and achievements.

Results and Benchmarks

Three-year trends are presented below. HEDIS rates successively improved by 15.06% during the time that interventions were introduced, analyzed, refined, and revised. Performance on this measure placed the health plan in the top 10% of health plans nationally and the second-highest performing plan in SC in measurement year 2017 (out of five plans). Preliminary analysis indicates that further increases will continue to be seen in 2018 — an anticipated result of further refining successful interventions.

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Overall Impact of South Carolina's Interventions to Increase the W15 HEDIS Measure

Over the course of three years, the health plan moved the Well-Child Visits in the First 15 Months of Life (six or more visits) (W15) measure from the 50th percentile to the 90th percentile (as shown in Figure 2), surpassing the state's goal by more than 13 percentage points. This is a measure in the state's quality withhold program and the health plan earned back the full amount at risk for the W15 category in 2017. Based on root cause analysis of performance gains in 2017, it was determined that the multifactorial approach to interventions that incorporated combined Member and provider outreach and communication were likely contributors to this sharp improvement. The health plan will expand the use of several of these successful QI strategies to NC, including Clinic Days, texting health-related reminders, LexisNexis MemberPoint, and the Healthy Rewards Member incentive program.

Transitional Care Outcomes

The health plan completes an annual evaluation of the transitional care management interventions across all lines of business. In September 2016, they revised the operational model to better align to the pillars of the Coleman Model. Actions included:

- Revised training with additional education and focus on the Coleman Model
- Development of additional management tools and reports to assist Care Managers (CMs)
- Creation of dashboards to track performance
- Best practice bimonthly meetings with CMs from all Medicaid health plans
- Implementation of the CM call immediately following a Member's discharge from the hospital to intervene proactively and resolve possible barriers to a successful transition

The health plan implemented the CM post-discharge call in 2016 and evaluated its impact on inpatient readmissions, finding ***a significant decline from 8.5% of Members readmitted in 2015 to 2.77% in 2016.***

Please provide the results (audited by a NCQA-approved auditing firm) under contract listed above for three (3) consecutive most recent HEDIS reporting periods within the past five (5) years available for the specific HEDIS metrics below. (If 3 reporting periods are not available, the Department will accept 2 or 1 reporting period measure results, as long as they are within the last 3 years)

	Year 2015	Year 2016	Year 2017
	Measure Result	Measure Result	Measure Result
1) Children and Adolescents' Access to Primary Care Practitioners (CAP)	12-24 months: 94.01 25 months-6 years: 85.17 7-11 years: 87.62 12-19 years: 84.97	12-24 months: 96.37 25 months-6 years: 85.07 7-11 years: 85.76 12-19 years: 83.69	12-24 months: 96.08 25 months-6 years: 85.99 7-11 years: 87.49 12-19 years: 85.73
2) Comprehensive Diabetes Control (CDC): Hemoglobin A1c (HbA1c) Poor Control (> 9.0%)	51.05	47.92	47.92
3) Follow-Up After Hospitalization for Mental Illness (FUH): 7 and 30-day periods	Not reported	Not reported	Not reported
4) Frequency of Ongoing Prenatal Care (FPC): all 5 percentage ranges	<21%: 7.50 21-40%: 3.70 41-60%: 6.89 61-80%: 15.83 >=81%: 66.08	<21%: 7.68 21-40%: 5.09 41-60%: 7.49 61-80%: 15.69 >=81%: 64.06	<21%: 9.56 21-40%: 4.11 41-60%: 7.88 61-80%: 15.22 >=81%: 63.23
5) Well-Child Visits in the First 15 Months of Life (6 or More Visits) (W15)	62.26	64.46	68.29

For any HEDIS metric results above that is less than the national average, please describe your remediation plan to improve performance in the area.

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Please describe any legal or adverse contractual actions, including sanctions and liquidated damages, that were incurred through the duration of contract listed above. Include the area of non-compliance, the date issued, the reason, the entity that issued it, the duration, and the resolution(s).

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Amerigroup Partnership Plan has a strong record of compliance with contractual obligations and requirements. Current contract with BlueChoice Health Plan of South Carolina, Inc. was effective on 7/1/2018. For transparency purposes and to align with disclosures required from Offerors in Question 10, Amerigroup Partnership Plan provides information for the past seven years. The table below lists adverse contractual actions, including but not limited to, requests for corrective action plan (CAP), liquidated damages, and sanctions received by Amerigroup Partnership Plan under this from 9/1/2011 through 8/31/2018.

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Signature

Date

Patrick H. Conway, MD

President and Chief Executive Officer

Printed Name

Title

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Offeror Name	AMERIGROUP Washington, Inc. (AMERIGROUP Washington) Relationship to Offeror: AMERIGROUP Washington, Inc. is an affiliate of our subcontractor, Amerigroup Partnership Plan, LLC.		
Contract Name	Apple Health and 3 other contracts (see services section for more detail)	Contact Person Name	Preston W. Cody
Name of Client	Washington Health Care Authority	Contact Person Title	Division Director
Annual Contract Value	REDACTED	Contact Person Telephone Number	360-725-1786
Contract Start Date	Apple Health Current: 1/1/2015 Original: 7/1/2012	Contact Person Email Address	Preston.Cody@hca.wa.gov
Contract End Date	12/31/2018	Geographic Area Served Under the Contract (e.g., Statewide, Regional)	Statewide
Scope of Services Provided Under Contract Listed Above (indicate Yes and number of staff assigned for all that apply)			
Managing Medicaid Managed Care beneficiary lives	Yes 10	Processing and paying claims	Yes 3
Provider network management	Yes 41	Assuming risk through capitated contracts	Yes 115 Health Plan employees supported by 44 shared services FTEs
Performing care management functions	Yes 77	Other [Please describe]	Yes 28 operations, quality marketing
Please describe the services provided under the contract listed above for each part answered "Yes" in Scope of Services Provided Under Contract Listed Above section.			
<u>Managing Medicaid Managed Care beneficiary lives</u> AMERIGROUP Washington, Inc. managed Medicaid managed care beneficiary lives under the following contracts:			

- Managed Care Contract — Apple Health — Responsible for the provision of physical health, behavioral health, LTSS, vision, and pharmacy for the following populations: TANF, CHIP, ABD, and Medicaid expansion.
- (Fully) Integrated Managed Care Contract – K2477 — Responsible for the provision of physical health, behavioral health, LTSS, vision, and pharmacy for the following populations: TANF, CHIP, ABD, and Medicaid expansion.
- Wraparound/WISe Contract — K2537 — Responsible for the provision of physical health, behavioral health, service coordination, and long-term care services for the following populations: TANF, CHIP, ABD, and Medicaid expansion.
- Foundational Community Supports K2240 Third Party Administrator — Third Party Administrator of Foundational Community Supports program in Washington facilitating supported employment and housing for Medicaid Members of all contracted managed care plans in Washington.

Provider Network Management

Services provided include the entire network management process:

- Network provider identification, recruitment, and development including providers with trauma-informed care training
- Contracting and credentialing/recredentialing
- Orientation, initial, and ongoing training
- Technical support
- Ongoing monitoring of network adequacy and support for quality and Value-Based Payment programs

Performing Care Management Functions

Services provided include:

- Predictive modeling and risk stratification
- Initial and ongoing care needs screening
- Comprehensive assessment/reassessment as needed and annually
- Developing, revising, and monitoring of the person-centered Member Care Plan including integration of other available treatment plans
- Coordination of services, supports, and community-based resources
- Consultation through multidisciplinary case rounds
- Monitoring performance against standards and requirements

Processing and Paying Claims

Services provided include end-to-end claims processes:

- Claims intake (electronic and paper)
- Front-end editing/validation, adjudication, provider payment, and remittance advice (electronic and paper)
- Quality auditing, and managing/monitoring claims operations against performance standards

Assuming Risk Through Capitated Contracts

AMERIGROUP Washington has provided services in Washington for over more than five years. Staffing has been adjusted over this timeframe to accommodate state needs, such as changes in program requirements and membership. The health plan currently has 115 full-time employees (FTEs) supplemented by 44 full-time employees provided by national shared services teams.

Staffing levels throughout the term of the contract may be adjusted based on changes in program requirements and membership.

An integral part of AMERIGROUP Washington's staffing plan is to hire local staff, at the necessary level and with the appropriate experience, to provide the highest quality services to Members and providers and supplement them with designated and dedicated national support shared services to leverage national best practices and economies of scale. The health plan makes sure staffing levels comply and exceed state requirements and continually reviews staffing numbers against quality and service standards to determine whether additional employees are needed to adequately provide the Member-centered care management and comprehensive provider support. Each manager and department routinely reviews their specific responsibilities and determines whether sufficient numbers of employees are committed to the department to meet staffing needs. Changes in membership volume, covered services and service areas, and general changes in operations are reviewed on an ongoing basis and staffing adjusted whenever necessary.

Other

Other functional areas supported include, but are not limited to, operations, quality, and marketing.

Please indicate the number of covered lives under contract listed above.

135,652

Please indicate the number of Practitioners and Providers in your network under contract listed above.

Provider Type	Unique Providers
PCPs (Includes Family Practice, Internal Medicine, Pediatrics, General Medicine, Geriatrics)	20,565
OB/GYN	1,471
Specialists	30,234
Facilities	708
BH Providers	7,354
FQHC	298

Please describe any key strategies or innovative approaches executed (e.g., system of care, staff, operations, technology, and relationship management) to advance high-value care, financial innovations or increase operational efficiency under contract listed above.

Collaboration with Federally Qualified Health Centers

AMERIGROUP Washington collaborated with a network Federally Qualified Health Center (FQHC) provider to review shared data on care gaps and identify Members who were not annually visiting their PCPs. The plan sent co-branded, tailored invitations to these Members asking them to call their PCP to schedule an annual visit and included the name and phone number of each Member's PCP. They also provided incentives to Members who subsequently completed their annual visit. Within a year of program start, more than 780 Members successfully visited their PCP.

Addressing Homelessness

The health plan collaborated with Projects for Assistance in Transition from Homelessness (PATH) through Washington's Catholic Diocese in Yakima, working on a foundational grant for suicide prevention. AMERIGROUP Washington worked with Catholic Child and Family Service on a Chelan County jail in-reach program to support inmates' mental health and substance use disorder needs before they are released to help reduce recidivism. In addition, the health plan worked with the Grant County Health District on a chronic disease grant, helping create access to the Diabetes Prevention Program to any Moses Lake resident who was eligible.

Outreach to American Indian/Alaskan Native Populations

AMERIGROUP Washington has been working with the Seattle Indian Health Board (SIHB) since 2015 to understand and develop services of importance and relevance to this specific population. The health plan's collaboration with SIHB has focused upon expanding and testing innovative techniques for whole person care, integrating medical and behavioral health (BH) services. This includes development of an acupuncture service based enhancement (SBE) coupled with endeavors to create a Traditional Healing Benefit for eligible American Indian/Alaska Native (AI/AN) Members throughout the Indian Health Service (IHS), Tribal 638, and Urban Indian Health Program system of care.

Through this collaboration, the health plan launched the Traditional Healing Benefits program. Program development included Annette Squetinkin Anquoe, Ph.D., SIHB's Traditional Health and Community Services Director, who wrote the definitions for AMERIGROUP Washington's traditional health SBE, which provides coverage for sweat lodge, talking circle, storytelling, and smudging services. The ongoing relationship with SIHB will facilitate future work improving access to care for AI/AN populations. Because of this work, SIHB has commended the plan's commitment to culturally appropriate care as, "by far the most responsive community health support we have received from any Managed Care Entity."

Outreach to Immigrant Communities and People Experiencing Homelessness

AMERIGROUP Washington has been supporting outreach programs at Neighborhood House (NH) since 2014. NH is one of the oldest social service agencies in the Puget Sound region, providing support services to over 12,000 economically disadvantaged community Members annually. This includes the use of a mobile health van that improves access for homeless populations by providing health screening, such as HIV and Hepatitis C (HCV) testing, in the community. The van provides a level of anonymity, which improves engagement of populations who are at high-risk and hard-to reach in a safe and private manner. The health plan has deployed the van to health fairs and community events at High Point, Rainier Vista, New Holly, Greenbridge, Rainier Beach, Tent City (White Center/Burien), Navos (Burien), Myers Way/Roxbury, and Renton.

In its first few months of use, NH used the van to provide health information, drug and alcohol prevention, and referral services to over 1,000 people. NH also provided rapid HIV and HCV testing to 25 individuals; one tested preliminary positive for Hepatitis C and was referred for

follow-up treatment, while four others were referred for BH services. In Renton, 35 people were tested, most of whom were experiencing homelessness and not connected to medical care. At the Somali Health Fair in 2017, six people were tested using the van; the prior year, when onsite testing without the van was offered, no one wanted to be tested. Additionally, NH connected several people at the Somali Health Fair to BH services.

Outreach to Vulnerable Populations: Cultural Ambassador Program

AMERIGROUP Washington is proposing a Cultural Ambassador Program to work in conjunction with their care coordination and Member outreach and advocacy teams. The health plan will engage Cultural Ambassadors from organizations who are already working and known in the community, such as promotoras, a specially trained group of Hispanic community workers who support individuals through health care system navigation. For example, promotoras will serve as supplemental points of contact to share information about the health plan's dental program in communities that have historically experienced barriers to care. The Cultural Ambassador Program will honor the different ways diverse populations prefer to receive information and referrals for health care services in order to increase the likelihood of them using dental services. The health plan will educate community partners on services available through the dental program, the importance of Dental Homes, and how to refer Members. This includes local public entities and community organizations, such as Head Start, WIC, and local health departments in advocating for the oral health needs of Members.

Outreach to Financially Vulnerable Children and Families

AMERIGROUP Washington has collaborated with the Seattle-based Tiny Tots Development Center since 2015 in order to reach families with information about health care. Tiny Tots provides childcare and early childhood education to 300 children per year, serving families from ethnically and financially diverse backgrounds. The center provides free preschool through the Early Childhood Education and Assistance Program (ECEAP) — 92% of children served by the center qualify for ECEAP and Medicaid. Their ethnically and culturally diverse staff speak a variety of languages, including Vietnamese, Somali, and Tagalog. The health plan provides training to Tiny Tots staff on Medicaid and other health insurance eligibility, enrollment, and benefits; early childhood development and preventive services; and benefits available to parents. Trained staff identify children and families eligible for coverage and assist in connecting them with coverage. Through this outreach, AMERIGROUP Washington has engaged families who may not have been familiar with options for health care, preventive care, or EPSDT services. Tiny Tots reports that prior to this collaboration, many children were not signed up for health insurance or accessing benefits and views this program as having a significant impact on increasing access to health care for the children and families they serve. Tiny Tots staff have built trusting relationships with parents and family Members and have become the right people to have conversations with families about their children's needs. Based on the positive results, the health plan has engaged community outreach contractors as part of its broader community engagement efforts.

Pharmacy Management Strategies

The health plan applies several proven strategies that successfully support and address substance use disorders (SUD). A January 2016 Center for Medicaid and CHIP Services Information Bulletin reported that Medicaid beneficiaries are prescribed painkillers at twice the rate of non-Medicaid patients and are at three-to-six times more at-risk for prescription painkillers overdose. Beyond preferred drug list (PDL) placement and drug criteria, the health plan supports step therapy, provider education and prescribing guidelines, drug utilization review (DUR), patient review and

restriction programs, and prescription drug monitoring. A few of the health plan's successful programs are described in the table below.

Program	Description
Controlled Substance Utilization Monitoring Program	Through its Controlled Substance Utilization Monitoring (CSUM) Program, the health plan educates providers about Members with an elevated use of a controlled substance as evidenced in pharmacy claims, advise them of appropriate prescribing practices, and emphasize the importance of monitoring use patterns. The health plan regularly shares de-identified prescriber data that helps providers compare their prescribing patterns to best practices and their peers and raise any Member-specific concerns. During the first 2 quarters of 2016, 69% of eligible Members reduced their claims for controlled substances to less than 10 at 180 days post intervention.
Lock-In Program	The health plan follows the state's lock-in program requirements and works with Members, prescribers, and pharmacies as appropriate to make sure Members are safe through early identification and ongoing screening, monitoring, and outreach activities that identify and engage needed services and supports.
BH Medication Management	The health plan implemented a medication management program designed to improve prescriber practices and Member adherence to appropriate medication treatment. The program promotes age-appropriate use of anti-psychotic medications and polypharmacy for children and older adults with a focus on identifying physician prescribing patterns and targeted education on best practices.

Please provide the results (audited by a NCQA-approved auditing firm) under contract listed above for three (3) consecutive most recent HEDIS reporting periods within the past five (5) years available for the specific HEDIS metrics below. (If 3 reporting periods are not available, the Department will accept 2 or 1 reporting period measure results, as long as they are within the last 3 years)

	Year 2015	Year 2016	Year 2017
	Measure Result	Measure Result	Measure Result
1) Children and Adolescents' Access to Primary Care Practitioners (CAP)	12-24 months: 96.20 25 months-6 years: 83.49 7-11 years: 88.60 12-19 years: 85.52	12-24 months: 95.94 25 months-6 years: 80.92 7-11 years: 86.88 12-19 years: 87.29	12-24 months: 95.37 25 months-6 years: 82.74 7-11 years: 85.88 12-19 years: 86.19
2) Comprehensive Diabetes Control (CDC): Hemoglobin A1c (HbA1c) Poor Control (> 9.0%)	43.16	52.20	33.80
3) Follow-Up After Hospitalization for Mental Illness (FUH): 7 and 30-day periods	No benefit	No benefit	No benefit
4) Frequency of Ongoing Prenatal Care (FPC): all 5 percentage ranges	<21%: 22.79 21-40%: 12.09 41-60%: 8.37 61-80%: 10.93 >=81%: 45.81	<21%: 21.90 21-40%: 12.86 41-60%: 7.14 61-80%: 15.71 >=81%: 42.38	<21%: 10.19 21-40%: 12.27 41-60%: 10.42 61-80%: 17.36 >=81%: 48.77
5) Well-Child Visits in the First 15 Months of Life (6 or More Visits) (W15)	58.10	68.41	71.96

For any HEDIS metric results above that is less than the national average, please describe your remediation plan to improve performance in the area.

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In its 2016 annual report, the Washington Medicaid External Quality Review Organization (EQRO) found that AMERIGROUP Washington scored the highest of all Medicaid health plans in antidepressant medication management measures for acute and continuation phases, and better than the state average for follow-up care for children prescribed with ADHD.

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Offeror Name	AMGP Georgia Managed Care Company, Inc. (Amerigroup Georgia) Relationship to Offeror: AMGP Georgia Managed Care Company, Inc. is an affiliate of our subcontractor, Amerigroup Partnership Plan, LLC.		
Contract Name	<ul style="list-style-type: none"> Georgia Families Georgia Families 360° programs 	Contact Person Name	Blake Fulenwider
Name of Client	Georgia Department of Community Health	Contact Person Title	Deputy Commissioner
Annual Contract Value	REDACTED	Contact Person Telephone Number	404-657-7739
Contract Start Date	Current: 7/1/2018 Original: 6/1/2006 (Georgia Families); 3/3/2014 (Georgia Families 360°)	Contact Person Email Address	blake.fulenwider@dch.ga.gov
Contract End Date	6/30/2019 (four renewable options remain)	Geographic Area Served Under the Contract (e.g., Statewide, Regional)	Statewide
Scope of Services Provided Under Contract Listed Above (indicate Yes and number of staff assigned for all that apply)			
Managing Medicaid Managed Care beneficiary lives	Yes 13	Processing and paying claims	Yes 17
Provider network management	Yes 103	Assuming risk through capitated contracts	Yes 279 Health Plan employees supported by 120 shared services FTEs
Performing care management functions	Yes 210	Other [Please describe]	Yes 56 operations, quality marketing
Please describe the services provided under the contract listed above for each part answered "Yes" in Scope of Services Provided Under Contract Listed Above section.			
Managing Medicaid Managed Care Beneficiary Lives For the programs below, Amerigroup Georgia is responsible for the provision of PH, BH, long-term, dental, vision pharmacy care, services, and supports. <ul style="list-style-type: none"> Georgia Families is the state's traditional Medicaid managed care program serving the TANF, CHIP, and Family Planning Waiver Members. 			

- Georgia Families 360° is a foster care and adoption assistance program that serves more than 378,000 Members and AMGP Georgia Managed Care Company, Inc. is the sole source vendor.

Provider Network Management

Services provided include the entire network management process:

- Network provider identification, recruitment, and development including providers with trauma-informed care training
- Contracting and credentialing/recredentialing
- Orientation, initial, and ongoing training
- Technical support
- Ongoing monitoring of network adequacy and support for quality and Value-Based Payment programs

Performing Care Management Functions

Services provided include:

- Predictive modeling and risk stratification
- Initial and ongoing care needs screening
- Comprehensive assessment/reassessment as needed and annually
- Developing, revising, and monitoring of the person-centered Member Care Plan including integration of other available treatment plans
- Coordination of services, supports, and community-based resources
- Consultation through multidisciplinary case rounds
- Monitoring performance against standards and requirements

Processing and Paying Claims

Services provided include end-to-end claims processes including:

- Claims intake (electronic and paper)
- Front-end editing/validation, adjudication, provider payment, and remittance advice (electronic and paper)
- Quality auditing and managing/monitoring claims operations against performance standards

Assuming Risk Through Capitated Contracts

Amerigroup Georgia has provided services in Georgia for over four years. Staffing has been adjusted over this timeframe to accommodate state needs, such as changes in program requirements and membership. The health plan currently has 279 full-time employees supplemented by 120 FTEs provided by national shared services teams. Staffing levels throughout the term of the contract may be adjusted based on changes in program requirements and membership.

An integral part of Amerigroup Georgia's staffing plan is to hire local staff, at the necessary level and with the appropriate experience, to provide the highest quality services to Members and providers and supplement them with designated and dedicated national support shared services to leverage national best practices and economies of scale. For both health plans, staffing levels comply and exceed state requirements. Both health plans continually review staffing numbers against quality and service standards to determine whether they need additional employees to adequately provide the Member-centered care management and comprehensive provider support. Each manager and department routinely reviews their specific responsibilities and determines whether sufficient numbers of employees are committed to the department to meet staffing needs.

Changes in membership volume, covered services and service areas, and general changes in operations are reviewed on an ongoing basis and staffing adjusted whenever necessary.

Other

Other functional areas supported include, but are not limited to, operations and quality marketing.

Please indicate the number of covered lives under contract listed above.

387,378

Please indicate the number of Practitioners and Providers in your network under contract listed above.

Provider Type	Unique Providers
Ancillary	653
Facility	152
OB/GYN	1,513
Pediatrics	1,363
Primary Care	4,724
Specialist	25,419
Total	33,825

Please describe any key strategies or innovative approaches executed (e.g., system of care, staff, operations, technology, and relationship management) to advance high-value care, financial innovations or increase operational efficiency under contract listed above.

In Georgia Families 360°, key strategies involve bringing together various providers and information systems to coordinate health services, individual needs, and information to promote safety, high-quality care outcomes, and improved quality of life.

Increasing Access by Meeting Individuals at Point of Entry

For the Georgia Families 360° program, Amerigroup Georgia designed the Juvenile Court Healthcare Integration Program (J-CHIP) to increase access and compliance. This focused intervention engages individuals at the juvenile court, the designated decision point of entry into the foster care program. The J-CHIP program is customizable according to the local community's needs and the desired involvement level of the juvenile court system. The type of local J-CHIP programs range from a full-service medical/dental/BH clinic sponsored by Amerigroup Georgia in the largest juvenile court in the State to partnership and case consultation regarding children with challenging conditions in others.

To help guide the local program development, the health plan hired a retired juvenile court judge as a consultant to make sure the programs meet the needs of their stakeholders. When judges in these counties decide a child should enter the child welfare system, the Division of Family and Children Services (DFCS) CM can take the individual to any Amerigroup Georgia network provider. The health plan has worked closely with its network to identify providers willing to see individuals on a walk-in or on-call scheduling basis immediately after the court hearing. These special accommodations assist in getting individuals timely care, without significant "back and forth" between the Georgia Department of Family and Children Services (DFCS) CM and the placement provider. The DFCS CM and caregivers also have the option to contact the health plan to assist with appointment scheduling. Appointments scheduled for the initial assessment become part of the court's records. During a subsequent hearing, the judge assesses compliance with timely completion of the initial assessment. This follow-up creates an important layer of accountability for all stakeholders involved.

Experience Working with Advocacy Groups and Stakeholders

Working with advocacy groups and stakeholders is a priority for Amerigroup Georgia. For Georgia Families 360°, the health plan created a separate Steering Committee composed of various child welfare stakeholders who assist in providing relevant population specific feedback, including on issues such as safety, quality, rights, and choice. Additionally, a special Community Education and Training Team works with a diverse set of stakeholders to enhance partnerships and facilitate a greater understanding of the Georgia Families 360° population and services. In 2016, the team conducted 332 presentations throughout the state, including with unique partners such as the Department of Juvenile Justice, law enforcement, Child Care Institutions, foster and adoptive parents, and DFCS.

Amerigroup Georgia also recently created a Transition Age Youth (TAY) workgroup to specifically outreach to youth ages 18-26 to make sure these individuals maintain or regain Medicaid coverage after aging out of the program. The workgroup consists of CMs, team leads, managers, marketing staff, and QI staff. The first workgroup convened in 2016, and its efforts have resulted in multiple new community partnerships with organizations such as the Coalition on Homelessness, Partnership for Community Housing, Family Menders, and Lost and Found Youth.

COACHES Program Offers Life Skills Training

The health plan launched the COACHES program in March 2014 with Families First, a local agency committed to providing safe and temporary housing and other supports for youth in foster care. The program's goal is to support young adults in gaining the knowledge and skills necessary to access health care services and prepare them for becoming resilient community citizens. The COACHES program targets:

- Reduction in hospitalization due to BH issues
- Increased access to medical and preventive health care services
- Changes in pregnancy-related behavior (such as increased participation in family planning, actively using contraception, longer pregnancy intervals)
- Increased completion of educational goals
- Increased employment

A care team consisting of the individual, the COACHES mentor, and an Amerigroup Georgia CM develop an integrated, holistic care plan. The plan addresses needs identified in initial and ongoing physical, psychosocial, and BH assessments, monitors treatment progress, and honors desired goals expressed by the individual. The COACHES program serves 34 counties in the state, and 79% of these counties are in rural or suburban areas. Because these areas have fewer centralized support services for youth aging out of foster care, and limited to no public transportation, the COACHES mentor travels on-site to work with the individual and the care team support is crucial.

Role and Responsibilities

Amerigroup Georgia refers individuals to the COACHES program and its Care Coordinators provide case management services as part of the integrated care team. Families First employs the COACHES mentors.

Outcomes

As of December 31, 2016, more than 500 Members had enrolled in the program. Participants are achieving positive results in the areas of wellness, physical health, education, and independent living skills. They are also showing increasing access to social services and experiencing lower medical costs. Key outcomes include:

- 21.4% decrease in health care expenditures
- 75% decrease in inpatient admissions
- 100% decrease in inpatient BH after three months working with the care team
- 22% increase in employment
- 32% increase in obtaining a GED
- Increased use of social services, educational services, job support, and health supports

System Changes that Improve Quality and Outcomes

Amerigroup Georgia participates in the Multi-Agency Alliance for Children (MAAC) Permanency-focused, Action-oriented, Collaboration, Team-based (PACT) program. PACT has resulted in innovations and changes in the service delivery system that enhance engagement with youth to improve potential success and sustainability in a community environment. The ultimate goal is to make certain each youth has a voice in their plan, has strong and consistent advocacy, accomplishes goals, and is safe and stable in a community setting. Amerigroup Georgia was a key partner in launching the PACT program, which focuses on the following:

- Improving relationships amongst youth, families, community providers, and DFCS partners
- Decreasing stays in higher level placements
- Effectively moving youth to permanent living arrangements
- Increasing sustainable connections

Amerigroup Georgia CMs refer individuals meeting the following criteria into the program including individuals who are:

- In a psychiatric residential treatment facility (PRTF) but do not meet medical necessity criteria for a PRTF stay
- Ready to step down from a PRTF but need additional supports to assure a successful transition
- In a Crisis Stabilization Unit (CSU) but do not qualify for a PRTF and can be safely served in the community
- In custody or at eminent risk of having a placement disruption or who have had multiple placements within 12 months

The PACT program resulted in a 60.2% reduction in costs during the first six months of operation. These costs savings were primarily driven by decreased inpatient and emergency room (ER) admissions. In 2017, the program continued to produce positive outcomes, including the following:

- 72% of participants have maintained school stability
- 86% of participants experienced some level of behavioral health stability
 - Youth remained in the community with no CSU or PRTF admissions
 - Youth maintained medication regimen or changed medication per prescriber recommendation
 - Youth attended psychiatric appointment as appropriate
- 11% reduction in service utilization, including ER, inpatient, outpatient, primary care, and specialty services

Case Management Satisfaction Outcomes

Amerigroup Georgia surveys overall satisfaction with its care management services on an annual basis. In 2016, survey results indicated:

- 94% of respondents indicated overall satisfaction
- 97% of respondents indicated satisfaction with their CM
- 91% of respondents expressed a likelihood to recommend the program
- 87% of respondents indicated the program helped their situation get better
- 94% of respondents indicated services were provided timely

- 88% of respondents indicated the program helped them make their life better

Sample QAPI Case Study

Amerigroup Georgia has been continuously engaged in a multi-year QAPI process to improve maternity and postpartum care services that affect a large number of Members in Georgia. The plan averages 1,100 deliveries monthly, and term pregnancies and deliveries are within the top 10 inpatient diagnoses for the plan's Members over the age of 19. This QI program aims to improve clinical quality indicators, maternity outcomes, and access to prenatal and postpartum care and education, which will ultimately lead to more efficient and appropriate utilization of benefits.

History of the Topic Selection

The American College of Obstetricians and Gynecologists (ACOG) recommends that women see their health care provider at least once between four and six weeks after the birth which aligns with the related HEDIS measure. In addition, improving postpartum care rates is a component of the Reproductive Life Plan protocol — an evidence-based tool recommended by the Centers for Disease Control and Prevention (CDC). Georgia's Medicaid health plans participated in a collaboration to obtain grant funding and implement the Reproductive Life Plan protocol locally. Additionally, CMS developed a goal to increase the rate of postpartum visits among women in Medicaid and CHIP by 10 percentage points, in 20 states over a three-year period.

Implementation and Evaluation of the PIP

Amerigroup Georgia implemented the Post-Partum Care Performance Improvement Project (PIP) in response. The PIP was initially implemented when, through in-depth barrier analysis, the health plan identified several challenges that could impact a woman's ability to complete a timely postpartum visit, including having social supports to attend the visit, health of the baby, transportation, belief that a C-section incision check is the postpartum visit, providers scheduling visits outside of the measure timeframe, and providers' process to contact Members who may have missed an appointment. The health plan implemented interventions incrementally, using the Plan-Do-Study-Act (PDSA) process as the cornerstone of their PIP process for continuous improvement while identifying root causes of lower than desired performance. Interventions were adjusted as needed to achieve continuous measureable improvements. Interventions that Amerigroup Georgia employed to improve postpartum care rates began in 2015, and incorporated a three-pronged approach which involved:

- **The Member approach**, implemented in 2015, involved outreach calls from the plan to new moms, making sure new moms were scheduled for a postpartum care appointment
- **The Provider approach** involved the provision of provider monetary incentives to garner their support in making sure Members came in for the post-partum visit; this approach has evolved to include additional process improvements that facilitate provider-led Member outreach. Later, the plan began faxing provider offices reports to inform when a Member needs to receive a postpartum visit; the provider then faxes back evidence of the visit within that timeframe to receive a bonus (incentive) payment.
- **The Data Approach** involved establishment of an incentive payment process to encourage providers to report claims via category II codes – this was implemented in response to data missing because of global reimbursement for maternity care.

In 2016, the plan implemented additional interventions through the OBQIP — a level 2C payment model in the HCP-LAN APM framework that rewards providers financially for improved quality. The health plan's OB Practice Consultant conducts in-person meetings and ongoing webinars with OB providers and their office staff to discuss OBQIP progress and assess trends and OB practice

patterns. They also provide information on aspects of the health plan's comprehensive Maternal-Child program that are relevant — like how to work with Members with SUD and available programs such as New Baby, New Life and Healthy Rewards Member incentives for prenatal and postpartum care. This information guides providers and improves satisfaction, while bringing back key information to the health plan that helps to define future provider programs and processes.

Approach to Evaluation of Interventions

While the plan used traditional evaluation methodologies to assess some interventions, there was also a descriptive pre-post analysis methodology applied to assess the OBQIP initiative. Rates for practices participating in the OBQIP were compared year-over-year with the baseline of 2015 identified as having occurred prior to program implementation and follow-up data obtained in 2016. The evaluation also compared the results obtained by providers participating in OBQIP to results from a matched sample of Members attributed to other providers in Medicaid network over the same period. Matching was conducted on Member months, pregnancy risks, and clinical features.

Results and Benchmarks

In evaluating the QI program performance, it was found that postpartum visits increased. Other measures monitored indicate that the education component of the program improved other outcome measures as well. The HEDIS postpartum care rate for timeliness of postpartum visits successively improved historically, in particular over the three-year time period (2015–2017) during which interventions were introduced, analyzed, and revised to make sure that goals were attained. The 2017 measurement rate for postpartum care (67.55) ranked as the highest rate in the state (one out of three) and within the NCQA 50th percentile.

Within the same timeframe, Amerigroup Georgia also introduced the OBQIP to providers and then studied the results of this innovative payment incentive program. Because of OBQIP, further decreases were realized in low birth weight births, preterm births, and overall C-section rates. The table below provides a summary of these other impacted rates that were a focus of later interventions through OBQIP initiatives — multiple outcome measures simultaneously improved following the 2016 implementation.

HEDIS Measures	Medicaid Average (GA 2015)	Pre-OBQIP Baseline (GA 2015)	Post-OBQIP Implementation (GA 2016)
Overall C-Section Rate	40.5%	34.4%	31.2%
Low Birthweight	10.4%	8.9%	8.5%
Preterm Births	7.2%	7.0%	5.1% (statistically significant)

Impact of Interventions to Increase Postpartum Visits and Improve Maternity Care

Amerigroup Georgia successfully increased postpartum care visits through interventions introduced to increase Member and provider awareness, and to improve access to data in order to capture accurate activities.

These interventions were progressively implemented following 2012; the health plan realized incremental increases over time, followed by more significant increases in recent years after introducing more aggressive initiatives to partner with the provider community to reach and engage more Members, employing improved data sharing as well as through the OBQIP initiative.

Rates of C-section, preterm birth, and low birth weight events were measurably lower among providers participating in the OBQIP than other Medicaid providers in the state. The program

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showed the powerful impact of reducing C-sections more than three percentage points year-over-year in participating practices and in achieving a statistically significant decrease in preterm births.

Please provide the results (audited by a NCQA-approved auditing firm) under contract listed above for three (3) consecutive most recent HEDIS reporting periods within the past five (5) years available for the specific HEDIS metrics below. (If 3 reporting periods are not available, the Department will accept 2 or 1 reporting period measure results, as long as they are within the last 3 years)

	Year 2015	Year 2016	Year 2017
	Measure Result	Measure Result	Measure Result
1) Children and Adolescents' Access to Primary Care Practitioners (CAP)	12-24 months: 97.00 25 months-6 years: 90.85 7-11 years: 92.99 12-19 years: 90.68	12-24 months: 96.61 25 months-6 years: 89.42 7-11 years: 92.23 12-19 years: 89.92	12-24 months: 97.12 25 months-6 years: 89.71 7-11 years: 92.06 12-19 years: 89.51
2) Comprehensive Diabetes Control (CDC): Hemoglobin A1c (HbA1c) Poor Control (> 9.0%)	58.54	53.22	51.58
3) Follow-Up After Hospitalization for Mental Illness (FUH): 7 and 30-day periods	7 days: 51.01 30 days: 70.29	7 days: 50.40 30 days: 67.73	7 days: 49.09 30 days: 67.43
4) Frequency of Ongoing Prenatal Care (FPC): all 5 percentage ranges	<21%: 16.32 21-40%: 8.62 41-60%: 12.35 61-80%: 14.69 >=81%: 48.02	<21%: 19.35 21-40%: 10.49 41-60%: 6.06 61-80%: 14.45 >=81%: 49.65	<21%: 10.65 21-40%: 7.41 41-60%: 9.49 61-80%: 13.89 >=81%: 58.56
5) Well-Child Visits in the First 15 Months of Life (6 or More Visits) (W15)	65.97	68.52	71.69

For any HEDIS metric results above that is less than the national average, please describe your remediation plan to improve performance in the area.

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Please describe risks and issues under contract listed above.

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Please describe results and value achieved under contract listed above.

Additional successes and highlights include maintaining NCQA commendable accreditation with more than a 5% improvement in HEDIS measures for NCQA scoring. Strong focus on Member outreach and engagement in 2017 resulted in more than 5,000 care gap appointments, and 3,163 EPSDT Screenings (the plan met the EPSDT CMS Screening Ratio of 88% for Georgia Families 360°). Amerigroup Georgia outperformed competitors overall on performance results with more than 73% of HEDIS measures exceeding competitor measures; and 81% of HEDIS hybrid measures demonstrating year over year improvements.

Please describe lessons learned under contract listed above.

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Signature Date

Patrick H. Conway, MD President and Chief Executive Officer
Printed Name Title

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Offeror Name	AMERIGROUP Maryland, Inc. (AMERIGROUP Maryland) Relationship to Offeror: AMERIGROUP Maryland, Inc. is an affiliate of our subcontractor, Amerigroup Partnership Plan, LLC.		
Contract Name	Managed Care Organization HealthChoice Provider Agreement	Contact Person Name	Jill Spector
Name of Client	Maryland Department of Health	Contact Person Title	Director, HealthChoice and Acute Care Administration
Annual Contract Value	REDACTED	Contact Person Telephone Number	410-767-5248
Contract Start Date	6/1/1999	Contact Person Email Address	jill.spector@maryland.gov
Contract End Date	Evergreen	Geographic Area Served Under the Contract (e.g., Statewide, Regional)	Statewide
Scope of Services Provided Under Contract Listed Above (indicate Yes and number of staff assigned for all that apply)			
Managing Medicaid Managed Care beneficiary lives	Yes 32	Processing and paying claims	Yes 3
Provider network management	Yes 40	Assuming risk through capitated contracts	Yes 205 health plan employees supported by 43 national shared services FTEs
Performing care management functions	Yes 81	Other [Please describe]	Yes 92 operations, quality marketing
Please describe the services provided under the contract listed above for each part answered "Yes" in Scope of Services Provided Under Contract Listed Above section.			
AMERIGROUP Maryland is one of the state's largest MCOs and the largest in Baltimore City and the counties of Baltimore, Montgomery, and Prince George's. The health plan delivers meaningful value through provider collaborations and engagement, enhanced affordability through cost of care and care management, and superior solutions for a better, more personalized health care experience.			

Managing Medicaid Managed Care Beneficiary Lives

AMERIGROUP Maryland is responsible for the provision of physical health, long-term care, vision, and pharmacy services for TANF, CHIP, ABD, and Medicaid Expansion populations.

Provider Network Management

Services provided include the entire network management process:

- Network provider identification, recruitment, and development including providers with trauma-informed care training
- Contracting and credentialing/recredentialing
- Orientation, initial, and ongoing training
- Technical support
- Ongoing monitoring of network adequacy and support for quality and value-based payment programs

Performing Care Management Functions

Services provided include:

- Predictive modeling and risk stratification
- Initial and ongoing care needs screening
- Comprehensive assessment/reassessment as needed and annually
- Developing, revising, and monitoring of the person-centered Member Care Plan including integration of other available treatment plans
- Coordination of services, supports, and community-based resources
- Consultation through multidisciplinary case rounds
- Monitoring performance against standards and requirements

Processing and Paying Claims

Services provided include end-to-end claims processes:

- Claims intake (electronic and paper)
- Front-end editing/validation, adjudication, provider payment, and remittance advice (electronic and paper)
- Quality auditing, and managing/monitoring claims operations against performance standards

Assuming Risk Through Capitated Contracts

AMERIGROUP Maryland has provided services in Maryland for nearly 20 years. Staffing has been adjusted over this timeframe to accommodate state needs, such as changes in program requirements and membership. The health plan currently has 205 full-time employees supplemented by 43 FTEs provided by national shared services teams. Staffing levels throughout the term of the contract may be adjusted based on changes in program requirements and membership.

An integral part of AMERIGROUP Maryland's staffing plan is to hire local staff, at the necessary level and with the appropriate experience, to provide the highest quality services to Members and providers and supplement them with designated and dedicated national support shared services to leverage national best practices and economies of scale. Our staffing levels comply and exceed state requirements. AMERIGROUP Maryland continually reviews staffing numbers against quality and service standards to determine whether they need additional employees to adequately provide

Amerigroup Maryland currently rates as a 4-star health plan by NCQA, has achieved Commendable accreditation status, and currently exceeds the 75th percentile across key HEDIS® and CAHPS® measures.

Their 2016 child CAHPS overall health plan measure received high satisfaction rating from 88.1% of respondents. This rate exceeds the HealthChoice Aggregate of 85.3% for that measure.

<p>Member-centered care management and comprehensive provider support. Each manager and department routinely reviews their specific responsibilities and determines whether sufficient numbers of employees are committed to the department to meet staffing needs. Changes in membership volume, covered services and service areas, and general changes in operations are reviewed on an ongoing basis and staffing adjusted whenever necessary.</p> <p><u>Other</u></p> <p>Other functional areas supported include, but are not limited to, operations, quality, and marketing.</p>													
<p>Please indicate the number of covered lives under contract listed above.</p>													
<p>275,814</p>													
<p>Please indicate the number of Practitioners and Providers in your network under contract listed above.</p>													
<table border="1"><thead><tr><th>Provider Type</th><th>Unique Providers</th></tr></thead><tbody><tr><td>Ancillary</td><td>784</td></tr><tr><td>Hospital</td><td>50</td></tr><tr><td>Primary Care</td><td>2,958</td></tr><tr><td>Specialist</td><td>14,290</td></tr><tr><td>Total</td><td>18,082</td></tr></tbody></table>	Provider Type	Unique Providers	Ancillary	784	Hospital	50	Primary Care	2,958	Specialist	14,290	Total	18,082	
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Community Health Worker for Hypertensive Members

AMERIGROUP Maryland's CHW program objective was to demonstrate hypertension control improvement for 30% of the enrolled target population by June 29, 2016, with an intervention timeframe of February 1 through June 29, 2016. Target populations included 1,453 hypertensive Members who received care at Baltimore Medical System (BMS). The grant period was from August 19, 2015 through June 29, 2016, with total funding of \$50,000 from the state through CDC. AMERIGROUP Maryland collaborated with BMS to engage over 200 hypertensive Members with care management and health coaching with a goal of hypertension: NQF 18 blood pressure control <140/90. During the duration of the program, the health plan achieved the following outcomes:

- BMS enrolled 491 out of 1,453 eligible Members with hypertension the CHW program
- BMS implemented morning hurdles with CHWs participating to identify targeted patients
- 37% experienced a decrease in their overall diastolic and systolic blood pressure results
- 18% moved from uncontrolled to controlled blood pressure

Collaboration with Federally Qualified Health Centers

Mary's Center for Maternal and Child Care is an FQHC that AMERIGROUP Maryland has collaborated with for the past four years through a PQIP. Mary's Center has four practice locations, 45 providers, and currently serves 2,211 AMERIGROUP Maryland Members. The health plan meets with Mary's Center monthly to review data results and prioritize activities and outreach initiatives. A Mary's Center staff member works daily to contact Members who are due for preventive care or other services, with an 80% success rate for scheduling appointments. In 2016, AMERIGROUP Maryland began focusing on reducing ER visits, effectively using the health plan's Provider Care Management Solution (PCMS) Report. Mary's Center uses the PCMS report to contact Members to advise them of the availability of same-day appointments and evening hours, and explain when it is necessary to go the ER.

Mary's Center is exceeding performance targets across selected preventive and well care measures and reducing ER visits. They accomplished this through ongoing collaboration and daily analysis of the reporting resources and tools they provide, including the State's regional health information exchange (HIE), Chesapeake Regional Information System for our Patients (CRISP). Quality improvement is ongoing and Mary's Center is in the process of implementing telemedicine.

The health plan has other similar collaborative PQIP relationships with other FQHCs across Maryland, including BMS, which has several School Based Health Centers, 108 participating providers, and is providing services to nearly 10,000 of AMERIGROUP Maryland's Members across six locations.

Provider Education and Collaboration

AMERIGROUP Maryland reduces the administrative burden for providers by taking CRISP notifications of admissions and automatically creating an authorization in the plan's management information system (MIS). The health plan also offers Learning Collaborative events to network providers that focus on best practices in practice management, Member engagement, appointment availability, and other relevant topics are discussed at the Learning Collaboratives. Attendees discuss their successes and gaps in performance and collaborate with each other and the health plan to develop initiatives and measurable goals. Follow-up with the practitioners is provided to assist practices in the implementation of best practices.

For example, in 2016, AMERIGROUP Maryland evaluated the health plan's HIV/AIDS care and population management, exploring opportunities to improve health outcomes related to identifying Members, linking Members to care, closing quality care gaps, reducing the incidence of avoidable

hospital admissions, and managing medical cost. Results indicate that opportunities for improvement may be available through utilizing data from CRISP, predictive modeling, providers, and other resources to locate and link Members to care, all of which has been included in the health plan's performance improvement plan for 2017.

Diabetes Prevention Program Grant

In 2016, AMERIGROUP Maryland was selected by the state to participate in a demonstration project to pilot a Diabetes Prevention Program (DPP) with Medicaid recipients and to develop a sustainable reimbursement model for this kind of programming. Maryland was one of two states awarded funding for this two-year project by the National Association of Chronic Disease Directors. The health plan was awarded \$158,758 in grant funding to collaborate with CDC-recognized Diabetes Prevention Programs, which included the following facility- and community-based and virtual programs:

- **Saint Agnes Medical Group.** Planned enrollment of 50-100 program participants in Baltimore City and Baltimore County
- **Soul So Good Healthy, Inc.** Planned enrollment of 50-100 program participants in Prince Georges and Montgomery County
- **Omada.** Planned enrollment of 25-50 program participants in a virtual program
- **RetroFit.** Planned enrollment of 25-50 program participants in a virtual program

Centering Pregnancy

AMERIGROUP Maryland offers The Centering Pregnancy Group Care Model (Centering Pregnancy), which delivers prenatal guidance from a certified nurse-midwife and medical professional to women with similar gestational ages, typically over a six-month period. The health plan encourages Members who are pregnant to participate in this evidence-based model through organizations such as the March of Dimes. AMERIGROUP Maryland has had tremendous success with this model serving nearly 350 women through this collaboration with the March of Dimes in 2017.

Health Information Exchange

AMERIGROUP Maryland uses the Chesapeake Regional Information System for our Patients (CRISP) and its data to:

- Help CMs understand and gain insight into a Member's clinical background, using CRISP's Clinical Query Tool as another asset
- Identify address and telephone information for hard to locate Members
- Notify CMs and a Member's PCP of an ER or inpatient/discharge event to facilitate prompt and effective intervention
- Reduce provider administrative burden by automatically generating required authorizations in the health plan's MIS from CRISP notifications, eliminating a step for providers (development in process)
- Push Member risk scores to CRISP daily, delivering access for Certified Health Homes

The health plan is working closely with CRISP to pilot new and future CRISP service offerings and the Plan President is on the CRISP Board of Directors and dedicated to supporting its goals. AMERIGROUP Maryland's Provider Relations Representatives also coach providers on the available CRISP services and the best ways to use CRISP data to improve the health and well-being of their Members.

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Please provide the results (audited by a NCQA-approved auditing firm) under contract listed above for three (3) consecutive most recent HEDIS reporting periods within the past five (5) years available for the specific HEDIS metrics below. (If 3 reporting periods are not available, the Department will accept 2 or 1 reporting period measure results, as long as they are within the last 3 years)			
	Year 2015	Year 2016	Year <u>2017</u>
	Measure Result	Measure Result	Measure Result
1) Children and Adolescents' Access to Primary Care Practitioners (CAP)	12-24 months: 97.66 25 months-6 years: 93.11 7-11 years: 95.28 12-19 years: 91.92	12-24 months: 97.85 25 months-6 years: 94.11 7-11 years: 96.10 12-19 years: 93.03	12-24 months: 97.58 25 months-6 years: 93.16 7-11 years: 96.45 12-19 years: 93.87
2) Comprehensive Diabetes Control (CDC): Hemoglobin A1c (HbA1c) Poor Control (> 9.0%)	38.50	42.16	39.58
3) Follow-Up After Hospitalization for Mental Illness (FUH): 7 and 30-day periods	No benefit	No benefit	No benefit
4) Frequency of Ongoing Prenatal Care (FPC): all 5 percentage ranges	<21%: 5.85 21-40%: 3.04 41-60%: 7.73 61-80%: 10.77 >=81%: 72.60	<21%: 5.21 21-40%: 4.69 41-60%: 5.99 61-80%: 10.68 >=81%: 73.44	<21%: 2.88 21-40%: 3.54 41-60%: 5.75 61-80%: 9.29 >=81%: 78.54
5) Well-Child Visits in the First 15 Months of Life (6 or More Visits) (W15)	65.35	74.31	67.36
For any HEDIS metric results above that is less than the national average, please describe your remediation plan to improve performance in the area.			

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<div>REDACTED</div>
<div>REDACTED</div>
<p>Please describe results and value achieved under contract listed above.</p> <p>AMERIGROUP Maryland has achieved great success with quality initiatives, increasing the number of HEDIS[®] measures exceeding the 75th percentile from 34% in 2014 to 56% in 2015. More than 23% of measures are above the 90th percentile. Additionally, the health plan has decreased cost in many areas, including continual declines in ER visits for the past four years. Results show that ER utilization decreased by 3.2% and ER visits for low acuity issues decreased by 8.6%. AMERIGROUP Maryland has consistently been among the top financially performing MCOs for controlling costs. The plan has earned numerous grants by the state and CMS for several years, and consistently operate 3-4% below HealthChoices MCOs in Maryland on a MLR basis.</p> <p>AMERIGROUP Maryland is a leader in directing care to the most cost-effective settings, demonstrating continuous year-over-year success. For example, between 2014 and 2016, by redirecting sleep studies to lower cost, same quality options like sleep clinics and in-home studies, the health plan reduced the number performed in the hospital by 76.7%. Moreover, by directing appropriate surgical procedures to freestanding outpatient surgical centers, AMERIGROUP Maryland reduced hospital surgeries by 26.3% during the same time. More than 152,000 Members</p>

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(54% of health plan Members) are attributed to PCPs or other providers participating in performance-based models.

The health plan collaborates with providers, stakeholders, and community resources to address SDOH and actively engages in opportunities to support Members' optimal health and well-being related to food security, transportation, housing, health literacy, educational level, and employment.

AMERIGROUP Maryland's relationship with AbsoluteCARE is a strong example of making sure Members have access to the right care at the right place and time. AbsoluteCARE, a health home model, combines all the primary health services chronically ill patients need in one facility, including professional care, in-house pharmacy, and laboratory. Additional services include mental health counseling, nutrition counseling, diabetes education, healthy cooking demonstrations, and meal planning. In the three-year relationship, AMERIGROUP Maryland achieved utilization and cost reduction in overall Member expense with significant drops in inpatient admissions/inpatient days/ER visits. In a comparison of 6 months before and after Members select AbsoluteCARE as their PCP, there was a 13.8% reduction in costs.

A key part of AMERIGROUP Maryland's data sharing strategy is the CRISP, the regional health information network serving Maryland and the District of Columbia. The health plan shares data with CRISP using bi-directional data feeds and accessing its online services to support near real-time hospitalization notification.

Please describe lessons learned under contract listed above.

REDACTED

CONFIDENTIAL

REDACTED

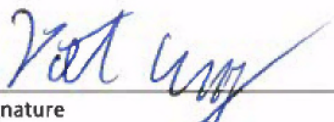
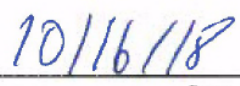
	
Signature	Date
<u>Patrick H. Conway, MD</u>	<u>President and Chief Executive Officer</u>
Printed Name	Title

Exhibit G

From: TIM.VAUGHN@bcbssc.com
To: Kilpatrick, Kimberley R
Sent: 12/17/2018 9:54:57 AM
Subject: [External] RE: NC Medicaid Reference Check – Blue Cross Blue Shield NC - RFP #30-190029-DHB
Importance: High
Attachments: PHP Client Reference Survey BCBS SC.docx

External email. Do not click links or open attachments unless verified. Send all suspicious email as an attachment to [Report Spam](#).

Kimberly,

I apologize but I thought I sent this on Friday but apparently it did not go.

Here you go and let me know if you have any questions.

Tim Vaughn

Timothy L. Vaughn
President and Chief Operating Officer
4101 Percival Rd, Columbia SC 29219
Office: 803-264-3364



This e-mail is confidential and subject to privilege:
<http://www.BlueChoiceSC.com/Confidentiality>

From: Kilpatrick, Kimberley R [mailto:kimberley.kilpatrick@dhhs.nc.gov]
Sent: Saturday, December 15, 2018 2:16 PM
To: TIM VAUGHN
Subject: [EXTERNAL] RE: NC Medicaid Reference Check – Blue Cross Blue Shield NC - RFP #30-190029-DHB
Importance: High

WARNING: This is an external email that originated outside of our email system. DO NOT CLICK links or open attachments unless you recognize the sender and know that the content is safe!

Good afternoon! Will you be able to complete the attached on behalf of BCBS of NC? We are continuing our evaluation process and would kindly accept all feedback. Thanks you in advance,

Kimberley Kilpatrick, Esq.
Contract and Compliance Specialist
Division of Health Benefits
[NC Department of Health and Human Services](#)

Office: 919-527-7015

NCDHHS-0056288

Kimberley.Kilpatrick@dhhs.nc.gov

820 S. Boylan Ave.
McBryde Building
Raleigh, NC 27603

1950 Mail Service Center
Raleigh, NC 27699-1950

[Twitter](#) | [Facebook](#) | [YouTube](#) | [LinkedIn](#)

From: Kilpatrick, Kimberley R
Sent: Tuesday, November 27, 2018 3:58 PM
To: TIM.VAUGHN@bcbssc.com
Cc: Kilpatrick, Kimberley R <kimberley.kilpatrick@dhhs.nc.gov>
Subject: NC Medicaid Reference Check – Blue Cross Blue Shield NC - RFP #30-190029-DHB

Good afternoon! My name is Kimberley Kilpatrick and I am the Contract Specialist with NC Medicaid managing our Prepaid Health Plans Request for Proposal as part of our transition to Managed Care. NC Medicaid is in the final stages of the evaluation process and are completing Offeror Reference checks. I have attached a brief questionnaire that I hope you will complete and return by December 14, 2018.

Blue Cross Blue Shield North Carolina Inc., submitted Amerigroup Partnership Plan, LLC subcontract with BlueChoice Health Plan of South Carolina, Inc., as one of their Offeror's Client References. As such, BlueChoice Health Plan of South Carolina, Inc. (BlueChoice of SC) was provided to serve as a reference. If this is not the correct contact person to provide this reference, please let me know.

Tim Vaughn, President
803-264-3364
TIM.VAUGHN@bcbssc.com

I realize how valuable your time is, and NC Medicaid thanks you in advance for your response.

Kimberley Kilpatrick, Esq.
Contract and Compliance Specialist
Division of Health Benefits
[NC Department of Health and Human Services](#)

Office: 919-527-7015
Kimberley.Kilpatrick@dhhs.nc.gov

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North Carolina Department of Health and Human Services

Division of Health Benefits

Offeror Reference Questionnaire for RFP # 30-190029-DHB Prepaid Health Plans

Your name was submitted as a professional reference by Blue Cross Blue Shield of North Carolina, Inc. ("Offeror"), who responded to the above referenced Request for Proposals (RFP). Please provide the following information by Friday, December 14, 2018. Contact Kimberley Kilpatrick at 919-527-7015 or Kimberley.Kilpatrick@dhhs.nc.gov if you have any questions.

Contact Information for Individual Providing Reference/Completing Questionnaire:

Name, Title	Tim Vaughn, President, BlueChoice HealthPlan of South Carolina		
Agency/Organization Name	Amerigroup Partnership Plan, LLC subcontract with BlueChoice Health Plan of South Carolina, Inc.		
Email Address	TIM.VAUGHN@bcbssc.com	Phone Number	803-264-3364

1. Please list/describe the service(s) performed by Offeror related to Medicaid Managed Care, including Provider Network Management, Care Management Functions, Processing and Paying of claims, Capitated Contracts, or other for Medicaid Managed Care Operations:

Amerigroup Partnership Plan, LLC provides the following activities but this list is not intended to be an all inclusive list but instead the key functions:

- Pharmacy PBM services
- Prepare, print and mail marketing material
- Actuarial analysis and services
- Medical Management to include Disease and Complex Case Management and Utilization Management
- NCQA-related Delegated and Support Services to include Quality Management
- Data entry and claims processing to include claims reporting to the Department
- Compliance support and reporting
- Call center systems and infrastructure to include IVR
- EDI gateway
- Systems support for interfaces and web access for eligibility, claims status and provider manuals
- Community outreach activities with responsibility
- Structure, advertise and participate in health fairs, health promotional events and provider education events
- Prepare, print and mail health promotion and provider education materials

2. Is the Offeror currently under contract with your organization/company?

☒ Yes ☐ No

If no, what is the end date of the last contract?

End date of last contract:

3. Number of years under contract	<input type="checkbox"/> < 1 year <input type="checkbox"/> 1 to 3 years <input type="checkbox"/> 3 to 5 years <input checked="" type="checkbox"/> More than 5 years	
4. Please rate Offeror's performance for items 4.a through 4.h on a scale of 1 to 5 as follows: 1 – Unsatisfactory: Does not meet expectations/performance standards 2 – Needs improvement: Partially meets expectations/performance standards 3 – Satisfactory: Fully meets expectations/performance standards 4 – Above expectations: Fully meets and often exceeds expectations/performance standards 5 – Exceptional: Fully meets and consistently or substantially exceeds expectations/performance standards		
a. Quality of work products/services provided	4 - Above expectations	
b. Timeliness of performance/adherence to deadlines	3 - Satisfactory	
c. Personnel experience, professionalism, technical skills, knowledge, etc.	4 - Above expectations	
d. Communications and cooperation with your agency /organization	4 - Above expectations	
e. Communication and cooperation with key external stakeholders, including beneficiaries and providers	4 - Above expectations	
f. Providing high-value, whole person care to beneficiaries	4 - Above expectations	
g. Ability to successfully implement key strategies or innovative approaches as directed by the contract	4 - Above expectations	
h. Compliance with the terms and requirements of the contract	4 - Above expectations	
i. Responsiveness in resolving conflicts, problems and escalations	3 - Satisfactory	
j. Cooperation and, if required, integration with other vendors	3 - Satisfactory	
k. Overall Performance	4 - Above expectations	
5. Would you hire/contract with Offeror again or have plans to do so?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
6. Please add any comments regarding the Offeror's adherence in meeting Service Level Agreements or Key Metrics: We have been in a partnership with Amerigroup Partnership Plan for over ten years and during that time we have not received any fines from the South Carolina Department of Health and Human Services. Over the ten years, we have had very few incidences where we did not meet 100% of the state-required service levels or key metrics.		

7. Please add any comments regarding the ratings or Offeror's performance, including areas of exceptional performance/ responsiveness or requiring improvement:

Amerigroup Partnership Plan is an extremely knowledgeable partner and has a wealth of experience in the Medicaid arena. The fact that we have been in a partnership with them for ten years and have an existing contract for subsequent years demonstrates their performance in support of our contract with the State of South Carolina.

The North Carolina Medicaid program appreciates your time and responses to this questionnaire.

Respondent's Memorandum in Opposition to
Aetna Better Health of North Carolina, Inc.'s
Motion and Memorandum for Leave to Amend
its Petition for a Contested Hearing

Exhibit 2

**Mona Moon
Deposition Excerpts**

IN THE OFFICE OF ADMINISTRATIVE HEARINGS

Optima Family Care of North Carolina,
Inc.,

COUNTY of WAKE

Petitioner,

19 DHR 01959

v.

North Carolina Department of Health
and Human Services, Mandy Cohen M.D.,
MPH in her official capacity as
Secretary of the Department and Dave
Richard in his official capacity as
Deputy Secretary of the Department of
NC Medicaid,

Respondents,

and

WellCare of North Carolina, Inc.,
Blue Cross and Blue Shield of North
Carolina, AmeriHealth Caritas of
North Carolina, Inc., Carolina
Complete Health, Inc.,

Respondent-Intervenors.

(Captions continued on page 2)

VOLUME I

DEPOSITION OF MONA MOON

September 19, 2019

Reporter: Wanda B. Constantino, CVR-CM-M
WORDSERVICES, INC.
1102 Driftwood Drive
Siler City, North Carolina 27344
919.548.4914
wanda@mywordservices.com

1 MR. KESSLER: No.

2 (Laughter.)

3 MR. KNOWLTON: We have a lot of chorus today.

4 MR. KESSLER: That would be fine. No problem.

5 COURT REPORTER: And for the record, if I hear
6 you, I'll note your name.

7 MR. KESSLER: As -- as we have done all along.
8 Great.

9 A. I apologize. What was your question?

10 BY MR. KESSLER:

11 Q. Certainly. Ma'am, you would agree with me, then,
12 that you understand that you had ultimate responsibility for
13 this particular procurement, correct?

14 MR. FLETCHER: Object to the form.

15 MR. ALEXANDER: Object to the form.

16 MR. KNOWLTON: Same objection.

17 A. As the chief operating officer, I am responsible
18 for Contracts and Procurement, but I do report up through a
19 chain of command within the Department. So I'm not sure I
20 would call it ultimate responsibility, but certainly I have
21 a large responsibility for the procurement.

22 BY MR. KESSLER:

23 Q. When you say "a large responsibility," what do you
24 mean?

25 A. Again, I'm leadership. Contracts reports to me.

1 A. Independent verification and validation services.

2 Q. Now I'm going to make you say that three times
3 fast. No, I'm kidding.

4 Those -- those are the only three procurements
5 that you have served on since -- since becoming the COO?

6 A. I believe that's correct.

7 Q. All right. When --

8 A. We had -- we had at least two smaller procurements
9 within Medicaid since I joined. They were -- one of them
10 was underway, so I can't remember if I was identified as an
11 evaluation committee member in -- in those documents or not.
12 That's why I said at least three.

13 Q. When was the first time that you became aware of
14 what is called consensus scoring?

15 A. I learned about consensus scoring when I was at
16 the State Health Plan which goes back to 2008. That's how
17 we handled procurements with the State Health Plan.

18 Q. And was it your idea to use consensus scoring in
19 this particular procurement?

20 A. I think it's fair to say it was my idea. As I
21 said, I'm responsible for procurement, and -- and we're
22 talking about discussions of how to handle the evaluation.
23 That was the experience that I had. It doesn't appear to be
24 unique, though.

25 Q. When you say it doesn't appear to be unique, what

1 -- what do you mean?

2 A. Well, State Procurement Manual identifies
3 consensus scoring of team is an appropriate mechanism for a
4 evaluation.

5 Q. Would you agree with me that it doesn't define
6 what consensus scoring is?

7 A. I don't know. It's a big manual.

8 Q. Understand. Do you recall whether it identifies
9 what consensus scoring is or how it works?

10 A. I don't -- I don't remember its -- seeing a
11 definition of it in the procurement manual.

12 Q. And had you ever served on a committee where
13 consensus scoring was utilized, meaning you actually were a
14 voting member on that particular committee?

15 A. Yes.

16 Q. All right. And that was when you were with the
17 state teachers, I'll refer to it as. Is that fair? State
18 teachers?

19 A. State Health Plan, yeah.

20 Q. State Health Plan. That would've been the first
21 time?

22 A. That I served as a voting member of an evaluation
23 committee?

24 Q. Uh-huh.

25 A. I think that's correct, yes.

1 reference the need to document the evaluation process and to
2 be fair and impartial.

3 Q. Right. But what I'm asking is -- is different.
4 I'm asking -- well, strike that.

5 Can you list for me today all of the -- or can you
6 list for me today, ma'am, the quality assurance approach
7 that was undertaken by the Department on this particular
8 procurement?

9 A. So, again, the quality assurance approach is a
10 review or -- of -- of the materials to be sure that the
11 information in the scoring tool, the Excel scoring tool;
12 that the notes that had been taken are reflective of the
13 committee's actions, decisions; that we have documentation
14 of any rating that was an "Exceeds" or "Substantially
15 Exceeds," or any rating that was a "Does Not Meet" or a
16 "Partially Meets"; that all of the information that we
17 requested from the offerors had been provided and that we
18 had scored the information and completed the scoring
19 process.

20 It is about double-checking things in the same way
21 that I reviewed my affidavit and if it wasn't correct, made
22 modifications. The same way that if I draft a memo or
23 create a presentation or anything else in the course of --
24 of the work that I do, I check it to be sure it's right.

25 Q. Is that the extent of the quality assurance

1 approach that was undertaken by the Department in this
2 particular procurement?

3 A. I don't know if I mentioned every single piece of
4 it, but --

5 Q. That's what I'm asking you.

6 A. -- it's -- it's an end-to-end review. We have a
7 summary of the evaluation process. Does it reflect the
8 steps? Again, did we look at the scores? Did we transfer
9 them to the Excel spreadsheet correctly? Is the Excel
10 spreadsheet working properly? Did we record all the scores?
11 So did we evaluate everything that came to us?

12 Q. And that is what you understand to be your quality
13 assurance approach for this procurement, correct?

14 A. Yes.

15 Q. Are you aware of any -- any other quality
16 assurance approach that was undertaken by the Department in
17 this specific procurement that we have not discussed or you
18 have not listed?

19 A. I'm not sure what -- I've -- I've answered the
20 question about end-to-end, so I'm not quite sure what else
21 you're -- you're asking me.

22 Q. I'm asking you, ma'am, to -- you would agree with
23 me quality assurance is important, correct?

24 A. Yes.

25 Q. All right. And from the very beginning you

1 A. -- in the -- the meeting notes and timeline. That
2 I had asked Kimberley to create a summary of all the
3 references and that it was noted that references were
4 returned and not scored.

5 And, again, that was something that I said, "If
6 we're not scoring something we received, I want to
7 understand why and make sure that that's a -- an appropriate
8 action, that we're not overlooking something that the
9 committee should be scoring."

10 Q. So I just want to be absolutely clear. I'm
11 talking about looking at -- or as part of the evaluation
12 process, reviewing all references. Not the dates they came
13 in, but going back and reviewing the references one more
14 time. Was that discussed during your meeting on January
15 14th with Ms. Crabtree and Ms. Kilpatrick?

16 A. And my answer was I don't remember if that was the
17 meeting that we discussed it or if it was a different date.

18 Q. Okay. Is there anything -- or do you have any
19 notes that would assist you in identifying when that
20 occurred?

21 A. I don't. (Reviewing document.)

22 Q. Just first answer if there -- if you have any.

23 A. I don't know if the meeting notes and timeline
24 might help me --

25 Q. Okay.

1 A. -- to determine that.

2 Q. Well, let me ask you this. Turn to Exhibit 163.

3 (Witness complied.)

4 Q. Would you agree with me that you typically review
5 e-mails from backwards to forwards?

6 A. Yes.

7 Q. Right? So let's go to the back. That would be --
8 the first page I'd direct you to is 218583. Do you see the
9 Bates numbers on the bottom?

10 A. I'm sorry, did you say --

11 Q. 218583.

12 A. Okay, yes.

13 Q. Right? So that's an e-mail that you would've sent
14 to Ms. Kilpatrick and Lotta Crabtree?

15 A. Yes.

16 Q. And the "Re" is "Not Returned Reference Check
17 Documentation Confidential Procurement Related." Is that
18 right?

19 A. Yes.

20 Q. And you copied Gregory Sligh?

21 A. Yes.

22 Q. And you thank -- you thanked Kimberley for sending
23 you -- sending you the e-mail that follows, that's behind
24 it, right? The e-mail of January 15th at 5:38 p.m.?

25 A. Yes.

1 Q. And then you're sending this at 7:03 p.m. Is that
2 right?

3 A. (Reviewing document.) Yes.

4 Q. Burning the midnight oil?

5 A. Not quite midnight yet.

6 Q. But long day, right?

7 A. Yes.

8 Q. And so what you do next is you say:

9 "While the phone message you left may have
10 requested a response by January 11th, only the
11 first email of the three included a request to
12 return by a certain date."

13 Do you see that?

14 A. Yes.

15 Q. All right. So the phone -- she did leave a phone
16 mail message requesting by January 11th, but what you were
17 pointing out is only the first e-mail of the three included
18 a request to return to -- to return those references by a
19 certain date. Is that what you were referencing? You were
20 referring to the references, right?

21 A. Yes.

22 Q. All right. And so when you say "only the first
23 email of the three included a request to return by a certain
24 date," do you know which e-mail you're referring to?

25 A. That would be the e-mail -- the first e-mail that

1 Kimberley sent to the clients requesting a reference back on
2 November 27th; that she requested a response by, I believe,
3 December 14th.

4 Q. Well, it says the phone message I left a --
5 requested a response by January 11th. So we -- we could be
6 -- this -- this indicates to me that we could be consistent
7 in saying that the phone call that was placed to each of the
8 outstanding references indicated that the responses had to
9 be completed by January 11th. Is that right?

10 A. Yes. The phone call that she made to each of the
11 outstanding references on January the 3rd, that in her voice
12 mail that she left, requested a response by January 11th.

13 Q. Okay. And you didn't get -- you didn't get all
14 the responses by that date. We already talked about that.
15 Remember?

16 A. Yes.

17 Q. All right. So you advised that Lotta and you
18 agreed that you should send one more e-mail to each of the
19 outstanding references asking for the form to be returned?
20 Right?

21 A. Yes.

22 Q. And this was dated January 15, 2019?

23 A. Yes.

24 Q. And you wanted the responses returned by 9 a.m. on
25 Thursday, January 17th.

1 A. That's correct.

2 Q. And you told her that if you draft something by 9,
3 the evaluation committee meeting -- we can -- we -- by the
4 9:00 meeting, we can share it with them, right?

5 A. (Reviewing document.)

6 Q. Last sentence?

7 A. Yes.

8 Q. And then she responds -- responds to you and said,
9 "Fine. I will send tonight." Right? That's at 7:06, three
10 minutes later?

11 A. Yes.

12 Q. And then a few moments after that, meaning two --
13 approximately two minutes after that, she sends you another
14 e-mail following up. Is that correct?

15 A. Yes.

16 Q. And she says, "Since we are doing this," and
17 "this" is sending out another notice for the references.
18 That's what "this" is referring to. Is that correct?
19 That's how you --

20 A. Yes.

21 Q. -- understood it?

22 Is there -- she says, "Is there something
23 different you want to do on the Blue Cross Blue Shield
24 reference?" Is that correct?

25 A. Yes.

1 Q. And so she then references that she advised you of
2 something in December. Do you see that?

3 A. Yes.

4 Q. What did she tell you -- well, first, what did she
5 tell you back in December of 2018 regarding the Blue Cross
6 Blue Shield reference?

7 A. She told me that there was a question from the
8 committee about one of the Blue Cross Blue Shield
9 references, that they didn't -- they were concerned it
10 wasn't really a client reference, and that they -- I don't
11 -- I don't remember the details of the conversation. I know
12 that this was something that Lotta was asked about; advised
13 them to be consistent.

14 I don't know if at the time that I had the
15 conversation with Kimberley if she was telling me there's
16 concern, we're going to seek some guidance, or if she was
17 telling me at that time they're not going to score it 'cause
18 they don't think it's a client reference.

19 Q. Well, let's go to Exhibit 13 and look at December
20 18th and 19th, if you will.

21 (Witness complied.)

22 Q. You were not at either meeting, is that correct,
23 on December 18th or 19th?

24 A. (Reviewing document.) No, I was not.

25 Q. All right. But you were apprised as to what

1 Q. And did you ever inquire during your due diligence
2 process the relationship between Blue Cross Blue Shield of
3 South Carolina and Blue Cross Blue Shield of North Carolina?

4 A. Did I ever -- I apologize. Did I --

5 Q. Did you ever -- during your due diligence in your
6 review of whether or not to accept this reference, did you
7 conduct an investigation to determine the relationship
8 between Blue Cross of -- Blue Cross Blue Shield of North
9 Carolina and Blue Cross Blue Shield of South Carolina that
10 was submitting a reference?

11 A. I didn't do any due diligence because, based on my
12 experience, they're two different companies. They're
13 separate --

14 Q. Okay. When you talk --

15 A. -- separate entities.

16 Q. -- when you talk about your experience, you've
17 worked with Blue Cross Blue Shield before. Is that right?

18 A. Blue Cross --

19 MR. KNOWLTON: Object to the form.

20 A. Blue Cross Blue Shield of North Carolina was a --
21 a contractor for the State Health Plan. So, yes.

22 BY MR. KESSLER:

23 Q. And how long -- and how many years -- how many
24 years have you worked with Blue Cross Blue Shield of North
25 Carolina?

1 MR. KNOWLTON: Objection to the form.

2 MR. FLETCHER: Object to form.

3 A. Blue Cross Blue Shield was the third-party
4 administrator for the State Health Plan for claims
5 processing and other related services during my entire
6 tenure at the State Health Plan, which was about eight
7 years.

8 BY MR. KESSLER:

9 Q. Had you ever met their CEO?

10 A. I have never met their current CEO, I don't
11 believe. Not in -- not in person.

12 Q. Do you know his name currently?

13 A. Patrick Conway or something like that.

14 Q. Dr. Patrick Conway?

15 A. Yes.

16 Q. So you had not met him previously?

17 A. No.

18 Q. But you had worked with many individuals from Blue
19 Cross Blue Shield over the years?

20 MR. FLETCHER: Object to form.

21 A. I knew people from Blue Cross Blue Shield from my
22 relationship with the State Health Plan or my employment
23 with the State Health Plan, yes.

24 BY MR. KESSLER:

25 Q. And their relationship with the State of North

1 Carolina was important. Is that fair?

2 MR. FLETCHER: Object to form.

3 A. They were the third-party administrator for the
4 State Health Plan; \$3 billion in claims. They were about
5 two billion of that. So, yes, I'd say that's significant.

6 BY MR. KESSLER:

7 Q. So that made them the largest private insurer that
8 the State of North Carolina had -- had been working with.
9 Is that fair?

10 A. The largest insurer that the State of North
11 Carolina worked with. And -- and based on what?

12 Q. The -- based on they had the -- they had the
13 largest contract from an insurance perspective relating to
14 providing health care in the State of North Carolina.

15 MR. FLETCHER: Object to form.

16 A. Blue Cross North Carolina, the value of the Blue
17 Cross contract in terms of the amount of claims that were
18 processed was the largest of the contracts for the State
19 Health Plan.

20 The State Health Plan also had contracts with
21 UnitedHealthcare and Humana, which also have large presence
22 in North Carolina, which is why including when you get into
23 Medicare space you start to get contracts for within North
24 Carolina that are much larger, so.

25 BY MR. KESSLER:

1 Q. All right. But as -- as you indicated previously,
2 still a very important relationship for the State of North
3 Carolina from your perspective.

4 A. Yes.

5 MR. FLETCHER: Object to form.

6 BY MR. KESSLER:

7 Q. And you had dealt with them from the time that you
8 first worked with the -- with the Department. Is that
9 correct?

10 A. Working with the Department being the State Health
11 Plan?

12 Q. Right.

13 A. Yes. They were the -- the third-party
14 administrator when I became employed by the State Health
15 Plan.

16 Q. And you worked with the State Health Plan from
17 2013 through 2017?

18 A. I worked with the State Health Plan --

19 Q. I'm sorry, 2008.

20 A. -- going back to 2008.

21 Q. Yeah. So you worked for the North Carolina State
22 Health Plan for teachers and state employees from 2008
23 through 2017 until you took your current job as COO of
24 Medicaid. Is that correct?

25 A. Yes.

1 Q. All right. And you also -- you also worked with
2 the Department of Health and Human Services from 2007 to
3 2008 before you moved over to becoming the chief financial
4 officer for the North Carolina State Health Plan for
5 teachers and state employees?

6 A. Yes.

7 Q. When was the first time that you started working
8 with Blue Cross Blue Shield?

9 MR. KNOWLTON: Object to form.

10 MR. FLETCHER: Object to the form.

11 A. When I started working for the State Health Plan,
12 they were the third-party administrator. That was the first
13 experience that I had with Blue Cross Blue Shield of North
14 Carolina.

15 BY MR. KESSLER:

16 Q. And they were the third-party administrator during
17 your entire tenure there?

18 A. Yes.

19 Q. I understand. Who did you deal with on a daily
20 basis or most frequently from Blue Cross Blue Shield?

21 MR. FLETCHER: Object to form.

22 A. Most recently it would have been Susan Murray. I
23 don't remember her title. She was a vice president for what
24 I'm going to call the state account.

25 BY MR. KESSLER:

Respondent's Memorandum in Opposition to
Aetna Better Health of North Carolina, Inc.'s
Motion and Memorandum for Leave to Amend
its Petition for a Contested Hearing

Exhibit 3

Deposition Exhibit 436



The Blue Cross Blue Shield System

MENU

Home > About Us

The Blue Cross Blue Shield System



Personalized Healthcare, Nationwide

Since 1929, Blue Cross Blue Shield (BCBS) companies have provided healthcare coverage to members, allowing them to live free of worry, free of fear. In every ZIP code, Blue Cross Blue Shield offers a personalized approach to healthcare based on the needs of the communities where their members live and work. They work closely with hospitals and doctors in the communities they serve to provide quality, affordable healthcare.

We understand and answer to the needs of local communities, while providing nationwide healthcare coverage that opens doors for more than 107 million members in all 50 states, Washington, D.C., and Puerto Rico. Nationwide, more than 96 percent of hospitals and 95 percent of doctors and specialists contract with Blue Cross Blue Shield companies — more than any other insurer.



[MENU](#)

The Blue Cross Blue Shield System

The Blue Cross Blue Shield Association is a national association of 36 independent, community-based and locally operated [Blue Cross Blue Shield companies](#). The Association owns and manages the Blue Cross and Blue Shield trademarks and names in more than 170 countries around the world. The Association also grants licenses to independent companies to use the trademarks and names in exclusive geographic areas.



Serving Our Federal Employees

The Blue Cross Blue Shield Federal Employee Program® is the top choice of U.S. federal employees, retirees and their families. Enrolling more than half of all U.S. federal employees, the Federal Employee Program covers roughly 5.6 million members, making it the largest single health plan group in the world.

[FEDERAL EMPLOYEE PROGRAM >](#)

Our Commitment to Labor

The BCBSA National Labor Office works hand in hand with organized labor to empower working Americans with health coverage that insures 1 in 3 Americans. Our 36 BCBS companies serve more than 17 million unionized workers, retirees and their families — more than any other insurer.

[NATIONAL LABOR OFFICE >](#)

MENU



The Blue Cross Blue Shield System



BCBS GLOBAL™

Blue Cross Blue Shield Global provides a full range of healthcare solutions for people who live, work and travel internationally.

[LEARN MORE](#)



[Careers](#)

[Contact Us](#)

[Healthcare Fraud](#)

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[Sitemap](#)



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The Blue Cross Blue Shield Association is an association of independent, locally operated Blue Cross and Blue Shield companies.

<https://www.bcbs.com/about-us/the-blue-cross-blue-shield-system>

MENU



The Blue Cross Blue Shield System

Respondent's Memorandum in Opposition to
Aetna Better Health of North Carolina, Inc.'s
Motion and Memorandum for Leave to Amend
its Petition for a Contested Hearing

Exhibit 4

Public Records on BCBNC

We Are Blue Cross NC

About Us

Since 1933, Blue Cross and Blue Shield of North Carolina (Blue Cross NC) has offered its customers high quality health insurance at a competitive price and has led the charge toward better health and more consumer-focused health care in our state. Blue Cross NC is a fully taxed, not-for-profit North Carolina company with major operations centers in Durham, Fayetteville, Winston-Salem, and an office in Charlotte. We employ more than 4,700 North Carolinians¹ and serve more than 3.89 million customers.²

Blue Cross NC is committed to making the health care system in North Carolina better – but we know we can't do it alone. That's why we work with doctors, hospitals and others to bring our customers innovative solutions that simplify the health care system, improve efficiency and outcomes, and help rein in costs.

Find important news, updates and press releases at our Media Center
(<http://mediacenter.bcbsnc.com/>)

Point of Blue

Have you visited our Blue Cross NC blog? We're making deeper connections with North Carolinians and finding new ways to provide real-time, dependable information about health care, wellness, healthy living and more!

Join us in the conversation (<http://blog.bcbsnc.com/>)

Our Provider Network

The Blue Cross NC PPO³ network of health care providers includes 96% of medical doctors and 99% of all general acute-care hospitals.⁴ When outside the state, our members have BlueCard[®] coverage with doctors and hospitals in all 50 states.

Community Involvement

Blue Cross NC employees work hard not only for our customers, but for the communities where they work and live. In 2015, Blue Cross NC employees contributed more than \$832,700 in our annual employee giving campaign. Matching contributions from the company resulted in a total of \$1.15 million invested in our communities⁵.

In addition to financial contributions, our employees donate their time and talents to a number of community causes. Since 1997, our employees have volunteered more than 399,178 hours at a value of over \$7.16 million in donated time⁶.

Our employees are deeply connected to the communities we serve, helping to construct KaBOOM! playgrounds alongside parent volunteers, packaging hundreds of thousands of meals in the annual Sort-a-Rama hunger relief effort, and giving their time to a range of other causes, including Backpack Buddies, Habitat for Humanity, Ronald McDonald House, Special Olympics and the Senior Games.

The Blue Cross NC Foundation — our company's separate, independent nonprofit foundation — is another outlet for deepening our connections with our neighbors across North Carolina. Founded in 2000, the Blue Cross NC Foundation's objective is to improve the health and well-being of all North Carolinians. The Foundation focuses on a number of priority areas, including:

- **Health Care:** Supporting safety net organizations and their partners in achieving measurable results to increase the quality, supply of and access to health care.
- **Healthy Living:** Increasing access to safe, inviting places to play and be active, as well as access to healthy local food.
- **Nonprofit Leadership:** Increasing the effectiveness of North Carolina nonprofit organizations and their leaders.

In 2018, BCBS companies made critical investments in health care in every ZIP Code across the US. We consider it our fundamental responsibility to improve the health of America. Those efforts are reflected in this report.

Read the Community Investment Report: The Health of America

(https://www.bcbs.com/sites/default/files/file-attachments/investing-health-america/HOA_Community_Report_2018_FINAL.pdf) (pdf)

We're a Fully Taxed Company

Blue Cross NC was founded as a nonprofit Medical and Hospital Services Corporation. Although we are structured as a nonprofit (no shareholders) corporation, the company is fully taxed and in 2015 incurred over \$272.0 million in federal, state and local taxes⁷. Blue Cross NC has not been tax exempt since 1973 (State) and 1986 (Federal) and it is not a 501 (c)(3) charitable organization.

Because we don't have shareholders, our net income is invested back into the company into things such as health programs for our members, customer service improvements and technology. It also contributes to our reserves, which represent the safety net for our customers in the event of an economic downturn or public health emergency.

Award-Winning Workplace

See all our corporate awards and recognition (<https://www.bluecrossnc.com/about-us/awards-and-recognition>) and find a rewarding career (<https://www.bluecrossnc.com/about-us/careers>) with the Blue Cross NC team.



More Awards and Recognition (<https://www.bluecrossnc.com/about-us/awards-and-recognition>)

Rewarding Careers (<https://www.bluecrossnc.com/about-us/careers>)

- 1 Employment numbers as of 3/25/2016
- 2 "Blue Cross 2015 Financials: ACA Losses Grow; Improvements in Other Lines of Business, Strong Investments Create Small Profit", Blue Cross NC press release, 2/26/2016
- 3 Preferred provider organization (PPO includes State PPO and Federal Employee Program PPO).
- 4 The percentage of medical doctors and hospitals is based upon the number of providers that applied for a Blue Cross NC provider number and then contracted with us versus the total number of providers who applied.
- 5 Blue Cross NC community relations data, 2/8/2016.
- 6 Blue Cross NC community relations data, 2/8/2016.
- 7 "Blue Cross 2015 Financials: ACA Losses Grow; Improvements in Other Lines of Business, Strong Investments Create Small Profit", Blue Cross NC press release, 2/26/2016
- 8 4th Quarter Corporate Goals Results, 4/11/2016
- 9 Blue Cross NC claims data, 4/11/2016
- 10 Blue Cross NC claims data, 4/11/2016
- 11 Blue Cross NC customer service data (2015 Phone Report), 4/11/2016

12 www.ncqa.org (Accessed March, 2016)

13 Awarded by the Ethisphere Institute, <https://www.worldsmoethicalcompanies.com/honorees/> (<https://www.worldsmoethicalcompanies.com/honorees/>) (Accessed March, 2016)

ABOUT US (/ABOUT-US)
Governance and Leadership (/about-us/governance-and-leadership)
Affiliates (/about-us/affiliates)
Media Center (http://mediacenter.bcbsnc.com/)
Policies and Best Practices (/about-us/policies-and-best-practices)
Awards and Recognition (/about-us/awards-and-recognition)
Vendor Resources (/about-us/vendor-resources)

Respondent's Memorandum in Opposition to
Aetna Better Health of North Carolina, Inc.'s
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its Petition for a Contested Hearing

Exhibit 5

**Public Records on BlueChoice
of SC**



Company Overview

Established in 1946 in Greenville, SC, BlueCross BlueShield of South Carolina is a mutual insurance company now headquartered in Columbia, SC. We have major offices in Columbia, Florence, Surfside Beach, Greenville, Charleston and Camden, SC; Dallas, Texas; Augusta, GA; and Nashville, TN – all serving multiple lines of business.

The BlueCross BlueShield division of the company offers health insurance to individuals and small groups in South Carolina. It also provides administrative services for larger, self-funded group health plans in South Carolina.

Subsidiary companies offer products related to other types of insurance, such as life, mental health and substance abuse benefits. The largest subsidiaries administer federal Medicare and TRICARE contracts. Some subsidiaries are technology-focused, offering back office claims processing, cloud hosting and other services to outside companies on our data centers.

The only South Carolina-owned and operated health insurance carrier, BlueCross is a major supporter of community and charitable causes in all of its locations. It also supports health care related research, education and service in South Carolina through the BlueCross BlueShield of South Carolina Foundation.

BlueCross is an independent licensee of the Blue Cross and Blue Shield Association. A.M. Best (www.ambest.com), the world's oldest and most authoritative insurance rating and information source, has rated our group of companies at A+ (Superior). This high rating is held by only a few health insurance companies in the nation.

Constituent Tools:

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BlueCross BlueShield of South Carolina is an independent licensee of the Blue Cross and Blue Shield Association.

[Non-Discrimination Statement and Foreign Language Access](#)



[Companion Benefit Alternatives](#)

Behavioral health benefits administrator for employer groups

[Companion Life](#)

Employee benefits specialist, marketing life, disability and dental insurance programs.

[Celerian Group](#)

Specialists in the diverse needs of state and federal government programs. Companies include:

[CGS](#)

Administrative services for healthcare programs and stakeholders.

[Companion Data Services \(CDS\)](#)

Secure systems development and managed hosting/outsourcing services; enterprise content and business process management solutions

[JBS International](#)

Research, evaluation, communications, information and management consulting in the health care, pharmaceutical and medical device industries

[Karna](#)

Health-related consulting services and support to Federal agencies in the areas of science, research and technology consulting.

[Palmetto GBA](#)

High-volume claims and transaction processing, contact centers, and technical services for federal government programs

[PGBA, LLC](#)

Fiscal intermediary and management information services for government programs and other large employers

[Planned Administrators, Inc. \(PAI\)](#)

Third party administrator (TPA) for self-funded plans, limited benefits and other consumer benefits.

[TCC of South Carolina](#)

Full-service third party administrator of fully insured and self-funded group health insurance.

FOR

[Shop Plans](#)
[Members](#)
[Providers](#)
[Employers](#)
[Agents](#)

ORGANIZATION

[About Us](#)
[Careers](#)
[Newsroom](#)
[Blog](#)
[Privacy & Legal](#)
[Rate Justification](#)

ASSISTANCE

[Contact Us](#)
[Find an Agent](#)
[Technical Support](#)
[Become a Supplier](#)
[Accessibility](#)
[Report Fraud](#)



[Non-Discrimination Statement and Foreign Language Access](#)

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BlueCross BlueShield of South Carolina is an independent licensee of the Blue Cross and Blue Shield Association

<https://www.southcarolinablues.com/web/public/brands/sc/about-us/family-of-companies/>





[Benefits](#) [Apply](#) [Care](#) [Get Help](#) [Your Account](#)[A A A](#) [Login](#) [Contact Us](#) [Provide](#)

Welcome to Healthy Blue

[!\[\]\(5a132f13505a6571904d622757b7a8f0_img.jpg\) FIND A DOCTOR](#)[!\[\]\(10f8862fc183b400327470ea85afe9ae_img.jpg\) HOW TO ENROLL](#)[!\[\]\(e1d6102fe77919492c04879c8450f1f5_img.jpg\) HOW TO RENEW](#)[!\[\]\(73002692dd5e7a64e60946be3158e719_img.jpg\) GET YOUR ID CAR](#)

Serving South Carolina Medicaid members

With Healthy Blue, you get the Medicaid benefits you need to live your best life.

-  **Doctor visits**
-  **Vision care**
-  **Dental care**
-  **Prescriptions**

[See all benefits](#)

Plus, free extras to keep your family healthy like:

24-Hour Nurseline

Talk to a registered nurse anytime, day or night. Get answers to your medical questions, and find a doctor or urgent care center near you.

[MORE](#) >

Transportation services

Never miss an appointment with free rides to your doctor's office. Get a ride to your pharmacy to pick up medications.

[MORE](#) >

Health and wellness discounts

Discounts for Jenny Craig® and Boys & Girls Club fees, free sports physicals for kids, and gift card rewards for pregnant members and new parents.

[MORE](#) >

Disease Management program

No-cost Disease Management program to help you manage conditions such as asthma, diabetes and major depressive disorder.

[MORE](#) >

Why choose Healthy Blue for your South Carolina Medicaid plan?

When you cover yourself in BlueSM, it's all about you.

- **Coverage close to home.** Our plan includes lots of doctors, hospitals and pharmacies to make getting care easy.
- **A name you can trust.** We have a history of caring, with more than 70 years of experience serving South Carolinians. We're part of the BlueCross BlueShield of South Carolina family of health plans. BlueCross is the oldest and strongest health insurer in South Carolina.
- **Free extra benefits on top of your regular Medicaid benefits.** You'll get benefits including no copays for urgent care and preventive visits, free car seats, and discounts on healthy lifestyle services like Jenny Craig® and Boys & Girls Club fees.
- **A company that makes a difference in the community.** Our [Family of BlueSM](#) gives back to the community. We promote good health and access to quality health care through community partners. Our funding supports free medical clinics, school nursing programs and other ways that help South Carolinians who need it most.

Updates and reminders

Ready for bad weather?

We're here to help! [Find out more](#) about how to keep your health in mind before an emergency.

Free interpreter and translation services available

If you do not speak English and need help during your doctor visit or when you call us, you can get help in your language. We also provide materials in other languages and formats, including Braille, large print and audio at no cost to you. Call our Customer Care Center and we'll get you the help you need.

[MORE](#) >

BabyNet Implementation News for Members

Starting October 1, 2019, Healthy Blue will take over the educational review and payment responsibility for BabyNet services. BabyNet is South Carolina's early intervention system for infants and toddlers through 3 years old with:

- Developmental delays
- Conditions associated with developmental delays

Healthy Blue will honor any Intensive Family Service Plan (IFSP) in place before 10/1/19 through the Coordination of Care period, which ends on 12/31/19.

What does this mean for you? You don't need an authorization during the Coordination of Care period for services with your current BabyNet provider. But, after 12/31/19, if your provider isn't a Healthy Blue participating provider, they will need to enroll with us to become one. Or, you may need to switch to a provider that offers BabyNet services that is in the Healthy Blue network.

If you have any questions about how this will impact you, please contact our Customer Care Center at 1-866-781-5094 (TTY 1-866-773-9634). You can reach us Monday through Friday, from 8 a.m. to 6 p.m.

Healthy Blue resources

[FIND A DOCTOR, HOSPITAL OR LAB >](#)

[KNOW WHERE TO GO – GETTING CARE 24/7 >](#)

[VIEW YOUR BENEFITS >](#)

[MEMBER HANDBOOKS AND MATERIALS >](#)

[GETTING THE MOST FROM YOUR BENEFITS >](#)

Member tools

[GET YOUR MEMBER ID CARD >](#)

[VIEW YOUR CONTACT INFORMATION >](#)

[RENEW YOUR BENEFITS >](#)

[CONTACT US >](#)

Have questions? Call us!

**Healthy Blue Customer Care Center 1-866-781-5094
(TTY 1-866-773-9634)**

Get translation and interpretation services free of charge.

Already a member? Log in to your account and [send us a message](#).

[Privacy](#) [Terms of Use](#) [Report Waste, Fraud or Abuse](#)

[Accessibility](#) [Our Quality Standards](#)

 [Get help in another language](#)

 [Nondiscrimination policy – English](#)

 [Nondiscrimination policy – Spanish](#)



BlueChoice HealthPlan is an independent licensee of the Blue Cross and Blue Shield Association. BlueChoice HealthPlan has contracted with Amerigroup Partnership Plan, LLC, an independent company, for services to support administration of Healthy Connections.

Respondent's Memorandum in Opposition to
Aetna Better Health of North Carolina, Inc.'s
Motion and Memorandum for Leave to Amend
its Petition for a Contested Hearing

Exhibit 6

Excerpts of Anthem, Inc. 10K

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

FORM 10-K

(Mark One)



**ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE
SECURITIES EXCHANGE ACT OF 1934**

For the fiscal year ended December 31, 2018
OR



**TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE
SECURITIES EXCHANGE ACT OF 1934**

For the transition period from _____ to _____
Commission file number: 001-16751

ANTHEM, INC.

(Exact name of registrant as specified in its charter)

INDIANA

(State or other jurisdiction of
incorporation or organization)

35-2145715

(I.R.S. Employer Identification Number)

**220 VIRGINIA AVENUE
INDIANAPOLIS, INDIANA**
(Address of principal executive offices)

46204
(Zip Code)

Registrant's telephone number, including area code: **(800) 331-1476**

Securities registered pursuant to Section 12(b) of the Act:

<u>Title of each class</u>	<u>Name of each exchange on which registered</u>
Common Stock, Par Value \$0.01	New York Stock Exchange

Securities registered pursuant to Section 12(g) of the Act: NONE

Indicate by check mark if the Registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes ☒ No ☐

Indicate by check mark if the Registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. Yes ☐ No ☒

Indicate by check mark whether the Registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes ☒ No ☐

Indicate by check mark whether the registrant has submitted electronically every Interactive Data File required to be submitted pursuant to Rule 405 of Regulation S-T (§232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit such files). Yes ☒ No ☐

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K (§229.405 of this chapter) is not contained herein, and will not be contained, to the best of registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. ☒

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, a smaller reporting company, or an emerging growth company. See the definitions of "large accelerated filer," "accelerated filer," "smaller reporting company," and "emerging growth company" in Rule 12b-2 of the Exchange Act. (Check one):

Large accelerated filer ☒
Non-accelerated filer ☐
Emerging growth company ☐

Accelerated filer ☐
Smaller reporting company ☐

If an emerging growth company, indicate by check mark if the registrant has elected not to use the extended transition period for complying with any new or revised financial accounting standards provided pursuant to Section 13(a) of the Exchange Act. ☐

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). Yes ☐ No ☒

The aggregate market value of the voting and non-voting common equity held by non-affiliates of the registrant (assuming solely for the purposes of this calculation that all Directors and executive officers of the registrant are "affiliates") as of June 29, 2018 was approximately \$61,871,738,688.

As of February 7, 2019, 257,011,928 shares of the Registrant's Common Stock were outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

Part III of this Annual Report on Form 10-K incorporates by reference information from the registrant's Definitive Proxy Statement for the Annual Meeting of Shareholders to be held May 15, 2019.

Anthem, Inc.
Annual Report on Form 10-K
For the Year Ended December 31, 2018

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References in this Annual Report on Form 10-K to the terms “we,” “our,” “us,” “Anthem” or the “Company” refer to Anthem, Inc., an Indiana corporation, and, unless the context otherwise requires, its direct and indirect subsidiaries. References to the term “states” include the District of Columbia, unless the context otherwise requires.

CAUTIONARY STATEMENT REGARDING FORWARD-LOOKING STATEMENTS

This Annual Report on Form 10-K, including Part II, Item 7, “Management’s Discussion and Analysis of Financial Condition and Results of Operations,” contains forward-looking statements within the meaning of the Private Securities Litigation Reform Act of 1995. Forward-looking statements reflect our views about future events and financial performance and are generally not historical facts. Words such as “expect,” “feel,” “believe,” “will,” “may,” “should,” “anticipate,” “intend,” “estimate,” “project,” “forecast,” “plan” and similar expressions are intended to identify forward-looking statements. These statements include, but are not limited to: financial projections and estimates and their underlying assumptions; statements regarding plans, objectives and expectations with respect to future operations, products and services; and statements regarding future performance. Such statements are subject to certain risks and uncertainties, many of which are difficult to predict and generally beyond our control, that could cause actual results to differ materially from those expressed in, or implied or projected by, the forward-looking statements. You are cautioned not to place undue reliance on these forward-looking statements that speak only as of the date hereof. You are also urged to carefully review and consider the various risks and other disclosures discussed in our reports filed with the U.S. Securities and Exchange Commission from time to time, which attempt to advise interested parties of the factors that affect our business. Except to the extent otherwise required by federal securities laws, we do not undertake any obligation to republish revised forward-looking statements to reflect events or circumstances after the date hereof. These risks and uncertainties include, but are not limited to: the impact of federal and state regulation, including ongoing changes in the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010, as amended, or collectively, the ACA, and the ultimate outcome of legal challenges to the ACA; trends in healthcare costs and utilization rates; our ability to contract with providers on cost-effective and competitive terms; our ability to secure sufficient premium rates, including regulatory approval for and implementation of such rates; competitive pressures and our ability to adapt to changes in the industry and develop and implement strategic growth opportunities; reduced enrollment; unauthorized disclosure of member or employee sensitive or confidential information, including the impact and outcome of any investigations, inquiries, claims and litigation related thereto; risks and uncertainties regarding Medicare and Medicaid programs, including those related to non-compliance with the complex regulations imposed thereon; our ability to maintain and achieve improvement in Centers for Medicare and Medicaid Services, or CMS, Star ratings and other quality scores and funding risks with respect to revenue received from participation therein; a negative change in our healthcare product mix; costs and other liabilities associated with litigation, government investigations, audits or reviews; the ultimate outcome of litigation between Cigna Corporation, or Cigna, and us related to the merger agreement between the parties, including our claim for damages against Cigna, Cigna’s claim for payment of a termination fee and other damages against us, and the potential for such litigation to cause us to incur substantial costs, materially distract management and negatively impact our reputation and financial condition; non-compliance by any party with the pharmacy benefit management services agreement between Express Scripts, Inc., or Express Scripts, and us, as well as any agreements governing the transition of pharmacy benefit management services provided to us from Express Scripts to CaremarkPCS Health, L.L.C., a subsidiary of CVS Health Corporation, which could result in financial penalties, our inability to meet customer demands, and sanctions imposed by governmental entities, including CMS; medical malpractice or professional liability claims or other risks related to healthcare services and pharmacy benefit management services provided by our subsidiaries; possible restrictions in the payment of dividends from our subsidiaries and increases in required minimum levels of capital; the potential negative effect from our substantial amount of outstanding indebtedness; a downgrade in our financial strength ratings; the effects of any negative publicity related to the health benefits industry in general or us in particular; failure to effectively maintain and modernize our information systems; events that may negatively affect our licenses with the Blue Cross and Blue Shield Association; large scale medical emergencies, such as future public health epidemics and catastrophes; general risks associated with mergers, acquisitions, joint ventures and strategic alliances; possible impairment of the value of our intangible assets if future results do not adequately support goodwill and other intangible assets; changes in economic and market conditions, as well as regulations that may negatively affect our liquidity and investment portfolios; changes in U.S. tax laws; intense competition to attract and retain employees; and, various laws and provisions in our governing documents that may prevent or discourage takeovers and business combinations.

PART I

ITEM 1. BUSINESS.

General

We are one of the largest health benefits companies in the United States in terms of medical membership, serving approximately 40 million medical members through our affiliated health plans as of December 31, 2018. We are an independent licensee of the Blue Cross and Blue Shield Association, or BCBSA, an association of independent health benefit plans. We serve our members as the Blue Cross licensee for California and as the Blue Cross and Blue Shield, or BCBS, licensee for Colorado, Connecticut, Georgia, Indiana, Kentucky, Maine, Missouri (excluding 30 counties in the Kansas City area), Nevada, New Hampshire, New York (in the New York City metropolitan area and upstate New York), Ohio, Virginia (excluding the Northern Virginia suburbs of Washington, D.C.) and Wisconsin. In a majority of these service areas, we do business as Anthem Blue Cross, Anthem Blue Cross and Blue Shield, Blue Cross and Blue Shield of Georgia, and Empire Blue Cross Blue Shield or Empire Blue Cross. We also conduct business through arrangements with other BCBS licensees in Louisiana, South Carolina and western New York. Through our subsidiaries, we also serve customers in over 25 states across the country as America's 1st Choice, Amerigroup, Aspire Health, CareMore, Freedom Health, HealthLink, HealthSun, Optimum HealthCare, Simply Healthcare, and/or UniCare. We are licensed to conduct insurance operations in all 50 states and the District of Columbia through our subsidiaries.

On February 15, 2018, we completed our acquisition of Freedom Health, Inc., Optimum HealthCare, Inc., America's 1st Choice of South Carolina, Inc. and related entities, or collectively, America's 1st Choice, a Medicare Advantage organization that offers health maintenance organization, or HMO, products, including Chronic Special Needs Plans and Dual-Eligible Special Needs Plans under its Freedom Health and Optimum HealthCare brands in Florida and its America's 1st Choice of South Carolina brand in South Carolina. At the time of acquisition, through its Medicare Advantage Plans, America's 1st Choice served approximately one hundred and thirty-five thousand members in 25 Florida and 3 South Carolina counties. This acquisition aligned with our plans for continued growth in the Medicare Advantage and Special Needs populations.

In October 2017, we established a new pharmacy benefits manager, or PBM, called IngenioRx, and entered into a five-year agreement with CaremarkPCS Health, L.L.C., or CVS Health, which is a subsidiary of CVS Health Corporation, to begin offering PBM solutions (the "CVS PBM Agreement"), which coincides with the conclusion of our current PBM agreement with Express Scripts, Inc. or Express Scripts, (the "ESI PBM Agreement"). In January 2019, we exercised our contractual right to terminate the ESI PBM Agreement earlier than the original expiration date of December 31, 2019 due to the recent acquisition of Express Scripts by Cigna Corporation, or Cigna. As a result of exercising our early termination right, the ESI PBM Agreement will now terminate on March 1, 2019, and the twelve-month transition period to migrate the business begins on March 2, 2019. At that time CVS Health is able to begin providing certain PBM services to IngenioRx pursuant to the CVS PBM Agreement. Notwithstanding our termination of the ESI PBM Agreement, the litigation between us and Express Scripts regarding the ESI PBM Agreement continues. In March 2016, we filed a lawsuit against Express Scripts seeking to recover damages for pharmacy pricing that is higher than competitive benchmark pricing and damages related to operational breaches. Express Scripts filed an answer to the lawsuit disputing our contractual claims and alleging various defenses and counterclaims. For additional information regarding this lawsuit, see Note 13, "Commitments and Contingencies - *Litigation and Regulatory Proceedings - Express Scripts, Inc. Pharmacy Benefit Management Litigation*," of the Notes to Consolidated Financial Statements included in Part II, Item 8 of this Annual Report on Form 10-K.

In May 2017, we announced that we were terminating the Agreement and Plan of Merger, or Cigna Merger Agreement, between us and Cigna. Both we and Cigna have commenced litigation against the other seeking various actions and damages, including Cigna's damage claim for a \$1.850 billion termination fee pursuant to the terms of the Cigna Merger Agreement. For additional information about the ongoing litigation related to the Cigna Merger Agreement, see Note 13, "Commitments and Contingencies - *Litigation and Regulatory Proceedings - Cigna Corporation Merger Litigation*," of the Notes to Consolidated Financial Statements included in Part II, Item 8 of this Annual Report on Form 10-K.

Respondent's Memorandum in Opposition to
Aetna Better Health of North Carolina, Inc.'s
Motion and Memorandum for Leave to Amend
its Petition for a Contested Hearing

Exhibit 7

Deposition Exhibit 428

Evaluation Question	
7.	<p>The Offeror shall provide a list of prior Medicaid Managed Care contracts, including states and regions that operated under a full risk Medicaid Managed Care capitated contract in or since 2012 in <i>Offeror's Proposal and Response Table 4: Medicaid Managed Care Contract Experience</i>. The completed table shall include the experience of the Offeror and any entity identified in Question #5.</p> <p>Quality metrics results included in <i>Attachment O. Offeror's Proposal and Response Table 4: Medicaid Managed Care Contract Experience</i> shall be for the three (3) consecutive most recent annual HEDIS reporting periods within the past five (5) years available for the specific HEDIS metrics below and audited by a NCQA-approved auditing firm.</p> <p>Offeror must fill out 1 table for each state, region, and/or contract that met the criteria listed in this question. Completed tables shall not be counted toward the Offeror's total page guidelines.</p>
Response	

Aetna's Quality Assurance and Performance Improvement (QAPI) program provides a framework for the planning, implementation, and monitoring of all processes that contribute to our commitment to providing integrated and high-value care. We evaluate the quality of our health care services using specific, objective performance and outcome measures from data sets such as Healthcare Effectiveness Data and Information Set (HEDIS), Consumer Assessment of Healthcare Providers and Systems, utilization data, grievances and appeals, and telephone customer services. The data is continually monitored to identify opportunities where we can better serve our members, stakeholders, and the community. Our organization-wide continuous quality improvement efforts lead to improved member and provider experiences; increased member access and satisfaction; maximized program efficiency while limiting operational costs; and continuous advancements in health and quality outcomes with an emphasis on increased efficacy and responsiveness.



Aetna contracts with a vendor that uses National Committee for Quality Assurance (NCQA)-certified HEDIS software to produce the measures, and we contract with a certified NCQA HEDIS auditor who reviews the systems and processes for data integration and performs medical record review. Aetna Better Health® of North Carolina does not have a prior Medicaid managed care contract in North Carolina. Aetna provides a list of prior Medicaid managed care contracts, including states and regions that operated under a full-risk Medicaid managed care capitated contract in or since 2012, in the following tables titled **Table 4: Medicaid Managed Care Contract Experience**. We include the experience of any entity identified in our response to **Evaluation Question 5**. Quality metrics results are for the three consecutive most recent annual HEDIS reporting periods within the past five years available²² for the specific HEDIS metrics listed and audited by a NCQA-approved auditing firm.

²² Effective reporting year 2018, NCQA retired "Frequency of Ongoing Prenatal Care" from the HEDIS measurement set; therefore there is no data to report for the most recent set of results. For this subsection, Aetna reports data from 2017, 2016, and 2015, if applicable.



Some of the information requested is not available (N/A) because of the following reasons: the measure does not apply to the population served by the contract, the denominator was too small, the relevant service was not a covered benefit under the contract, or the state did not require reporting on the measure. In cases where a health plan appears in our response to **Evaluation Question 5** but does not appear in the following tables, such health plan either reports HEDIS-like metrics that are not audited by a NCQA-approved auditing firm, or the contract does not require HEDIS measures.



Attachment O. Offeror's Proposal and Response Table 4: Medicaid Managed Care Contract Experience

State/Region	Year <u>2016</u>		Year <u>2015</u>		Year <u>2014</u>	
<u>Arizona</u>	Measure Result		Measure Result		Measure Result	
Entity (as identified in Question #5)	Southwest Catholic Health Network Corporation d/b/a Mercy Care Plan (now known as Mercy Care) ²³					
Performing Core Medicaid Operations Function (as identified in Question #5)	No					
Description of the entity's role(s) in performing the functions or responsibilities described in Offeror's Proposal (as identified in Question #5)	Through a Plan Management Services Agreement (PMSA), Aetna Medicaid Administrators (AMA) provides comprehensive management services for Mercy Care's Acute, Developmentally Disabled, Arizona Long Term Care System and D-SNP contracts. The referenced PMSA is from 8/15/16 however AMA has held the PMSA with Mercy Care since 5/1/2002. Through a separate PMSA, AMA also administers the Regional Behavioral Health (RBHA) contract in Maricopa County for Mercy Care.					
Contract Start Date	10/1/2013					
Contract End Date	8/30/2018					
Number of Beneficiaries Covered	352,029					
1) Children and Adolescents' Access to Primary Care Practitioners (CAP)	12 months – 24 months	93%	12 months – 24 months	96.2%	12 months – 24 months	98%
	25 months – 6 years	87.4%	25 months – 6 years	89.6%	25 months – 6 years	98.4%
	7 years – 11 years	92.2%	7 years – 11 years	93.1%	7 years – 11 years	93%
	12 years – 19 years	89.3%	12 years – 19 years	90.3%	12 years – 19 years	90.7%
2) Comprehensive Diabetes Control (CDC): Hemoglobin A1c (HbA1c) Poor Control (> 9.0%)	Not reported by State		51.1%		Not reported by State	
3) Follow-Up After Hospitalization for Mental Illness (FUH): seven (7) and thirty (30) day periods	7-day	47.3%	7-day	45.93%	7-day	32.89%
	30-day	59.46%	30-day	61.24%	30-day	40.79%
4) Frequency of Ongoing Prenatal Care (FPC): all 4	<21%	Not reported by State	<21%	Not reported by State	<21%	Not reported by State

²³ Mercy Care is not owned by Aetna Inc., but it is managed by Aetna Medicaid Administrators LLC (Aetna Medicaid Administrators), the same Aetna affiliate that will provide the majority of management services for Aetna Better Health of North Carolina. Aetna Medicaid Administrators provides plan management services to Mercy Care under a Plan Management Services Agreement (PMSA). Mercy Care, and not Aetna Medicaid Administrators, holds the Acute Care Contract directly with Arizona's Medicaid agency, the Arizona Health Care Cost Containment System (AHCCCS). This reference is from Mercy Care's Board Chair for the work Aetna Medicaid Administrators performs as the plan administrator, and not from AHCCCS.



Attachment O. Offeror's Proposal and Response Table 4: Medicaid Managed Care Contract Experience

State/Region	Year <u>2016</u>		Year <u>2015</u>		Year <u>2014</u>	
percentage ranges	21-40%	Not reported by State	21-40%	Not reported by State	21-40%	Not reported by State
	41-60%	Not reported by State	41-60%	Not reported by State	41-60%	Not reported by State
	61-80%	Not reported by State	61-80%	Not reported by State	61-80%	Not reported by State
	81+%	Not reported by State	81+%	Not reported by State	81+%	Not reported by State
5) Well-Child Visits in the First fifteen (15) Months of Life (6 or More Visits) (W15)	63%		69.3%		74.5%	

Respondent's Memorandum in Opposition to
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Motion and Memorandum for Leave to Amend
its Petition for a Contested Hearing

Exhibit 8

Jay Ludlam
Deposition Excerpts

IN THE OFFICE OF ADMINISTRATIVE HEARINGS

Optima Family Care of North Carolina, COUNTY of WAKE
Inc.,
Petitioner, 19 DHR 01959

v.

North Carolina Department of Health
and Human Services, Mandy Cohen M.D.,
MPH in her official capacity as
Secretary of the Department and Dave
Richard in his official capacity as
Deputy Secretary of the Department of
NC Medicaid,

Respondents,

and

WellCare of North Carolina, Inc.,
Blue Cross and Blue Shield of North
Carolina, AmeriHealth Caritas of
North Carolina, Inc., Carolina
Complete Health, Inc.,
Respondent-Intervenors.

(Captions continued on page 2)

VOLUME II

30(b)(6) Deposition of the
North Carolina Department of Health and Human Services
by and through its agency or representative,
Jay Ludlam

September 30, 2019

Reporter: Elaine F. Hayes, Court Reporter
WordServices, Inc.
1102 Driftwood Drive
Siler City, North Carolina 27344
919.548.4914

wanda@mywordservices.com

1 anything that they thought could be a conflict of interest
2 during the interview?

3 A. Yes.

4 Q. And who were those individuals?

5 A. The individual that raised a question to me was
6 Amanda Van Vleet.

7 Q. What question did Amanda Van Vleet raise to you?

8 A. So when -- based on her extensive experience, her
9 involvement at the Centers for Medicare and Medicaid
10 Innovations, Kaiser Family Foundation, Centers for -- I
11 think it's Health Leads -- I actually have the organization
12 wrong.

13 But her experience in Medicaid, working for a
14 representative from Arizona, and an interest in value-based
15 purchasing and other topics related to care and quality, I
16 -- we -- she and I were in the process of negotiating a role
17 within North Carolina Medicaid.

18 I suggested that she would be a good candidate to
19 serve on the evaluation committee because of the experience
20 I just listed and that's in her resumé, but I also thought
21 that it would be good for her to get right into Medicaid
22 managed care as she came to North Carolina Medicaid.

23 She and I talked about what being on the
24 evaluation committee would be like, and once she agreed that
25 she was interested in serving, she did raise the fact that

1 her boyfriend worked at Blue Cross Blue Shield.

2 Q. When Ms. Van Vleet raised the fact that her
3 boyfriend worked at Blue Cross Blue Shield, had she already
4 been hired by the Department?

5 A. No. She was in the process of -- we were in the
6 process of finalizing, and it was basically a done deal, but
7 I don't think we had finalized the actual paperwork.

8 MR. WOLFE: I realize we're after 5:00. Can we go
9 off the record?

10 (Off the record at 5:04 p.m.)

11 (Discussion off the record.)

12 (Back on the record at 5:06 p.m.)

13 BY MR. WOLFE:

14 Q. Ms. Van Vleet indicated to you that she -- her
15 boyfriend worked for Blue Cross Blue Shield. Is that Blue
16 Cross Blue Shield of North Carolina?

17 A. It's in North Carolina.

18 Q. Okay.

19 A. It's unrelated to the Medicaid program.

20 Q. Okay. When you say, "It's unrelated to the
21 Medicaid program" --

22 A. The organization that her boyfriend works for does
23 not -- it does not involve Medicaid, is what she reported to
24 me.

25 Q. Did you know what specific organization her

1 boyfriend was working for when she shared that information
2 with you?

3 A. She may have said it, but I don't have a -- I
4 don't recall it.

5 Q. Did you ask her whether it was unrelated to
6 Medicaid or did she volunteer that information?

7 A. No. I asked her -- when she said that she had a
8 boyfriend and that he worked for North -- for Blue Cross
9 Blue Shield, I asked if it was -- whether he was involved in
10 Medicaid. She said no.

11 I asked if he was involved in -- as far as she was
12 aware, if he was involved in the Blue Cross Blue Shield
13 procurement effort. She said no.

14 And I asked what he did, and she said that he was
15 -- he worked in value-based purchasing, developing value-
16 based purchasing strategies for the commercial line for Blue
17 Cross Blue Shield.

18 I then asked if she could be fair and objective
19 serving on the committee, and she said yes.

20 Q. Did you ask Ms. Van Vleet the name of her
21 boyfriend or did she ever volunteer the name of her
22 boyfriend during that conversation?

23 A. I don't remember her specifically saying or not
24 saying the name of her boyfriend. I think -- I don't
25 remember. I don't remember either way.

Respondent's Memorandum in Opposition to
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its Petition for a Contested Hearing

Exhibit 9

Deposition Exhibit 303

Jay Ludlam, J.D.

4601 Whitnire Pl
Raleigh, NC 27612

P 573-823-1708
E Jay.Ludlam@gmail.com

High-performing, recognized leader with proven accountability for managing a Medicaid state agency and leading others in identifying and resolving complex technical, operational and organizational problems.

EXPERIENCE

Department of Health & Human Services, Division of Health Benefits, RALEIGH, NC

ASSISTANT SECRETARY FOR MEDICAID TRANSFORMATION

AUGUST 2017 – PRESENT

Licensed to practice
law in Missouri

Executive lead for implementing state-wide Medicaid Managed Care program affecting over 1.6 million lives, including pregnant women & children transitioning from fee-for-service to managed care

MO HealthNet Division, JEFFERSON CITY, MO

ACTING MEDICAID DIRECTOR

JANUARY 2017 – AUGUST 2017

DEPUTY DIVISION DIRECTOR

AUGUST 2014 – DECEMBER 2016

Appointed lead of Missouri's Medicaid agency units with responsibility for budget and fiscal operations, information services, provider and participant support, human resources, and Medicaid program administration, in addition to providing health benefits to approximately 975,000 lives.

Recognized Leader

Executive Leadership
Program
(Missouri State
Government – 2017)

Essentials of Managed
Care Program
(WellCare – 2014)

Developing Leader
Program
(Aetna – 2013)

Medicaid Business Unit
Leadership Program
(Aetna – 2012)

Executive lead for implementing state-wide Medicaid Managed Care program expansion affecting over 750,000 lives, including pregnant women & children transitioning from fee-for-service to managed care:

- Implemented quality and care management innovations encouraging Medicaid delivery reform and market transformation such as health homes, certified community behavioral health centers (CCBHCs), and accountable care organizations (ACOs);
- Led division Medicaid Care Management reforms, including Care Management Organization accountability, provider responsibility for quality outcome and containing costs, participant incentives for healthy behaviors, integrating behavioral health care with physical health care, and empowering provider change;
- Developed innovative contract oversight program utilizing a process-risk approach, coupled with an expanded capitation-withhold program to control managed care organization operational and quality risks while maintaining actuarial rate soundness.

Closed \$27 million MO State Auditor finding through business process review (BPR) focused changes, increasing existing staff efficiency and potential third-party liability recovery at no additional cost to the Medicaid program.

Licensed to practice
law in Missouri

- Accountable for information service maintenance & operations, development, state-procurement, and contracting for MMIS, Business Information System-Enterprise Data Warehouse (BIS-EDW) and related-systems that verify eligibility, process claims, and reimburse providers for 100 million annual health care claims, authorizations, encounters, and point-of-service (POS) transactions annually.



MISSOURI ATTORNEY GENERAL'S OFFICE, JEFFERSON CITY, MO
ASSISTANT ATTORNEY GENERAL

MAY 2007 – AUGUST 2009

- Prosecuted white-collar criminal and civil fraud for Medicaid Fraud Control Unit.
- Negotiated criminal plea agreements and civil settlements, recovering \$1.3 million.
- Prepared criminal complaints, investigative subpoenas and search warrants; engaged in complex civil discovery and motion practice.
- Coordinated local prosecutors, investigators, auditors and computer analysts to develop cases for prosecution.
- Awarded \$1.8 million on summary judgment as part of civil prosecution case; affirmed by the Missouri Supreme Court (State v. Spilton, 315 S.W.3d 350 (Mo. banc 2010)).

MURPHY & TOBIN LAW FIRM, KANSAS CITY, MO
LAW CLERK

MARCH 2006 – MAY 2007

- Assisted with computer system lease enforcement and contract cases.

NEXTCARD, INC., SAN FRANCISCO, CA
DIRECTOR OF CUSTOMER LOYALTY PLATFORMS

OCTOBER 1998 – NOVEMBER 2002

- Awarded patent for developing real-time data interface and corresponding business logic to identify and obtain outstanding bank balance information. (On-line balance transfers, US 8010422).
- Identified the need for and developed a "one-click" email sales platform which improved net conversions and resulted in a 500% increase in email response rates.
- Successfully migrated 400,000 Rewards customers and points balances to a new vendor with minimal disruption to customer service or customer experience.
- Developed customer privacy policy - first credit card company to earn an eTrust Trustmark.
- Administered sites ranked #1 for online credit cards 4 out of 5 quarters (Gomez 2000-2001).
- Oversaw platforms that accounted for 25% of new assets from existing customers in 2001.

FAMILY EDUCATION COMPANY, BOSTON, MA
MARKETING ANALYST

JANUARY 1998 – JUNE 1998

- Enhanced online traffic measurement methods to improve reporting accuracy, visitor path analysis, and promotional tracking. Implemented "splash pages" to track campaign response, consumer demographics and site behavior.
- Devised and implemented online market research surveys to capture customer demographics and obtain customer feedback. Analyzed visitor usage reports and generated key learning to guide future visitor acquisition and retention efforts.

EDUCATION

Juris Doctorate – UNIVERSITY OF MISSOURI - KANSAS CITY

Bachelor of Arts, Social Psychology – GRINNELL COLLEGE

- Educational background [enclosed resume]
- Work experience [enclosed resume]
- Title and role with the Department;
 - Assistant Secretary for Medicaid
- Any specific experience with:
 - Medicaid; [enclosed resume +]

Medicaid Fraud Control Unit within the Missouri Attorney General's Office (2007-2009)

Prosecuted white-collar criminal and civil fraud for Medicaid Fraud Control Unit.

Negotiated criminal plea agreements and civil settlements recovering \$1.3 million.

Prepared criminal complaints, investigative subpoenas and search warrants; engaged in complex civil discovery and motion practice.

Coordinated local prosecutors, investigators, auditors and computer analysts to develop cases for prosecution.

Awarded \$1.8 million on summary judgment as part of civil prosecution case (aff'd, State v. Spilton, 315 S.W.3d 350 (Mo. banc 2010)).

Aetna/Missouri Care

Medicaid Compliance

Responsible for auditing, investigating, training/education and enforcement of federal and state laws and regulations for multiple Medicaid programs including Missouri, Indiana, New Hampshire and Maine.

Accountable for monitoring, reporting, adherence and implementing compliance controls, including related-company standards.

Oversees preparation and filing of regulatory reports and responses to regulator inquiries; negotiates resolution of issues identified.

Coordinates and oversees compliance audits and internal and external examinations; models ethical behavior in all situations.

Lead policy review of the Missouri health plan and managed administrative compliance to meet NCQA accreditation requirements

Aetna Claims Operations and Provider Setup Manager

Jun 2010 – Jun 2012

Identified need for systemic change and executed strategy to improve efficiencies with contract, benefit, and fee schedule configuration; 97% of projects completed within 60 days and \$450,000 annual cost savings.

Responsible for contract/benefit configuration and claims processing, appeals, reversals, and refunds.

Implemented S-OX contract validation controls on 250+ contract configurations.

Coordinates the technical implementation of physician / facility contract and roster loads including benefit, fee schedules and regulatory changes.

Develops and leads process and quality improvement initiatives.

Manages the coordination of benefits verification and third party liability coordination functions for the health plan.

Director of Operations (Sr. Manager of Claims)

Company NameMissouri Care, a WellCare Health Plan

Dates EmployedJun 2012 – Sep 2014

Employment Duration2 yrs 4 mos

LocationColumbia, MO

Led operational and clinical integration with a pediatric Medicaid accountable care organization, delegating health plan administration to encourage better population-based clinical management, medical home support and payment system reform to benefit providers and participants.

Leader of operational units at an NCQA accredited, managed care organization with multiple Medicaid / Medicare lines of business in Missouri and S. Illinois.

Responsible for all functions and staff in Provider Relations, Provider Operations and Configuration, Claims oversight, Call Center and Credentialing departments.

Guided departments through major milestones including NCQA Accreditation, expansion from 49k to 108k members, and a corporate acquisition, with focus on risk mitigation, value creation, compliance, and client and member satisfaction.

WellCare acquired Missouri Care from Aetna in April 2013.

- o Managed care; [enclosed resume]

Compliance or Operations experience in managed care for markets in Missouri, Maine, New Hampshire, Indiana (pharmacy prior authorization) contract, Southern Illinois and North Carolina

Local health plan compliance or operations experience – Missouri and Southern Illinois

Remote compliance – IN, ME, NH

State Medicaid Agency experience – MO, NC

Different program health plan experience included shutting down an ASO (MO), Medicaid Managed Care (MO, NC), PACE (MO)

- o Complex government programs;

NextCard – Regulation Z compliance (“Schumer box” disclosures); privacy

Missouri Care - Sarbanes-Oxley compliance (S-OX)

Attorney General’s Office

Medicaid – MMIS, ICD-10 conversion, State Auditor, Managed Care, PACE, implementation of largest/first in nation CCBHC demonstration, NC Transformation

- o Procurement;

At State Agencies (MO and NC) indirectly managed teams which drafted, initiated, procured, implemented or managed ongoing multiple contracts – eg: Third Party Liability renewal, BIS-EDW, MMIS, enrollment broker, EQRO, member ombudsman

Executed sole source contracts and negotiations for business services, IT and administrative

- o Contracts with vendors for managed care; [Enclosed resume] and
- o Any prior experience with a transformation to a Medicaid managed care system.

Conversion of Aetna health plan to a WellCare healthplan as part of the Aetna-Coventry merger settlement - in approximately 45-60 days.

Extended Missouri Medicaid into rural counties which had not had Medicaid Managed Care (May 2017)

North Carolina Transformation

Respondent's Memorandum in Opposition to
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its Petition for a Contested Hearing

Exhibit 10

Deposition Exhibit 199



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Sarah (Allen) Gregosky · 3rd

Medicaid Transformation with NCDHHS

Raleigh-Durham, North Carolina Area · 249 connections ·

[Contact info](#)NC Department of Health and
Human Services

UNC Chapel Hill

People Also Viewed

Steve Tedder · 3rd

Chief Information Officer at NC
Department of Health and Human
Services

Rajeev Kotrannavar · 3rd

IT Director, PMP at State of North
Carolina

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Director, Office of Healthy
Opportunities at NC Department of
Health and Human Services

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Transformation Specialist

Jean Holliday · 3rd

CPA

Trish R. · 3rd

Talent Leader| Engaging people,
Delivering results, Making a difference

Sonja McLeod

Human Services/Social Services
Administration

Beth Lovette · 3rd

Public Health Director at Appalachia
District Health Department

Kim Nunzi · 3rd

Practice Manager at North Carolina
Surgery

Lisa Gouin, PCMH CCE · 3rd

Practice Transformation Specialist
Alledade, Inc.

Experience

NC Department of Health and Human Services

2 yrs 11 mos

Deputy Director of Standard Plans

Nov 2018 – Present · 10 mos

Raleigh, North Carolina

Medicaid Transformation Program Office Lead

Oct 2016 – Nov 2018 · 2 yrs 2 mos

Senior Strategic Advisor, Strategic Planning and Performance Management

Blue Cross and Blue Shield of North Carolina

Sep 2015 – Oct 2016 · 1 yr 2 mos

Managing implementation of new reimbursement strategy for key provider specialties in BCBSNC commercial network, including engaging consultants to assist with current state review and future state strategy development, reviewing consultant recommendations for new reimbursement strategy, elevating recommendations to senior leadership, and facilitating biweekly discussions with contracting and implementation leads to ensure successful launch of strategy.... See more

Episode of Care Program Manager

TennCare

Jun 2013 – Aug 2015 · 2 yrs 3 mos

Greater Nashville Area, TN

Manage the ongoing implementation of the episode of care model across Tennessee's Medicaid Managed Care Organizations and state employee health plan commercial payers, including ensuring payers align on program requirements, meet the required implementation timeline, and communicate shared vision of the program with provider stakeholders

... See more

Health Reform Intern

North Carolina Department of Insurance

May 2012 – May 2013 · 1 yr 1 mo

Raleigh-Durham, North Carolina Area

Monitor and analyze regulatory updates related to Health Benefit Exchanges including tobacco-rating, quality and accreditation, Consumer Operated and Oriented Plans, SHOP Exchange and Medical Loss Ratios

Develop policy decision matrix related to the Small Business Health Options Program... See more

Learn the skills Sarah has

Project Management:

Government Projects

Viewers: 23,159

Learning Program

Messaging Management



Search

Senior Analyst

Towers Watson

May 2007 – Jul 2011 · 4 yrs 3 mos

Developed annual health benefit budgets for large employers based on historical claims experience and estimated medical trends

Analyzed vendor proposals for health and welfare benefits and create summary of analysis to be shared with senior management and executive committees... See more

[See more courses](#)**Education****UNC Chapel Hill**

MSPH, Health Policy and Management

2011 – 2013

Activities and Societies: AcademyHealth; UNC Healthcare Improvement Group, Student Chapter of Institute Healthcare Improvement

UNC Chapel Hill

BA, Economics and Political Science

2003 – 2007

Licenses & Certifications**IHI Open School Basic Certificate**

Institute of Healthcare Improvement

Issued Apr 2012 · No Expiration Date

Group Benefit Associate

International Foundation of Employee Benefit Plans

Issued Dec 2009 · No Expiration Date

Skills & Endorsements**Public Health** · 5

Endorsed by Mysha Sissine, who is highly skilled at this

Health Policy · 3

Wendy Melissa Pulley and 2 connections have given endorsements for this skill

Program Management · 3

Wendy Melissa Pulley and 2 connections have given endorsements for this skill

Industry Knowledge**Employee Benefits** · 2**Program Evaluation** · 1**Process Improvement** · 1**Health Insurance****Policy Analysis****Tools & Technologies****Stata****Other Skills** ②**Policy** · 1[Messaging](#)



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Messaging

Contact

www.linkedin.com/in/sarah-gregosky-4ab63645 (LinkedIn)

Top Skills

Health Policy
Employee Benefits
Public Health

Certifications

Group Benefit Associate
IHI Open School Basic Certificate

Sarah Gregosky

Medicaid Transformation with NCDHHS
Raleigh-Durham, North Carolina Area

Experience

NC Department of Health and Human Services
2 years 11 months

Deputy Director of Standard Plans
November 2018 - Present
Raleigh, North Carolina

Medicaid Transformation Program Office Lead
October 2016 - November 2018 (2 years 2 months)

Blue Cross and Blue Shield of North Carolina
Senior Strategic Advisor, Strategic Planning and Performance
Management
September 2015 - October 2016 (1 year 2 months)

Managing implementation of new reimbursement strategy for key provider specialties in BCBSNC commercial network, including engaging consultants to assist with current state review and future state strategy development, reviewing consultant recommendations for new reimbursement strategy, elevating recommendations to senior leadership, and facilitating biweekly discussions with contracting and implementation leads to ensure successful launch of strategy.

Overseeing enterprise-wide work group to evaluate and redesign reimbursement approach for residential treatment centers. Scope of work group includes analyzing and benchmarking current reimbursement methodology, estimating savings impact of reimbursement change, developing provider and member communications, and coordinating implementation across multiple claims and customer service platforms.

Providing ongoing support to Director of Health Economics and Planning in developing 5 year strategy to shift all BCBSNC providers from fee for service to fee for value contracting arrangements.

TennCare
Episode of Care Program Manager

June 2013 - August 2015 (2 years 3 months)

Greater Nashville Area, TN

Manage the ongoing implementation of the episode of care model across Tennessee's Medicaid Managed Care Organizations and state employee health plan commercial payers, including ensuring payers align on program requirements, meet the required implementation timeline, and communicate shared vision of the program with provider stakeholders

Develop materials for ongoing stakeholder meetings on the Tennessee Health Care Innovation Initiative, including weekly meetings with insurance companies, monthly meetings with providers, and ad hoc meetings with legislators and other interested parties

North Carolina Department of Insurance

Health Reform Intern

May 2012 - May 2013 (1 year 1 month)

Raleigh-Durham, North Carolina Area

Monitor and analyze regulatory updates related to Health Benefit Exchanges including tobacco-rating, quality and accreditation, Consumer Operated and Oriented Plans, SHOP Exchange and Medical Loss Ratios

Develop policy decision matrix related to the Small Business Health Options Program

Construct dashboard to monitor year over year Medical Loss Ratio results for NC insurers in individual, small and large group

Towers Watson

Senior Analyst

May 2007 - July 2011 (4 years 3 months)

Developed annual health benefit budgets for large employers based on historical claims experience and estimated medical trends

Analyzed vendor proposals for health and welfare benefits and create summary of analysis to be shared with senior management and executive committees

Benchmarked health and welfare benefits and costs for employers to support benefit changes or confirm alignment with market trends

Served as project manager for 3 – 5 client teams, monitoring weekly budgets, leading internal team meetings, and developing client deliverables

Education

UNC Chapel Hill

MSPH, Health Policy and Management · (2011 - 2013)

UNC Chapel Hill

BA, Economics and Political Science · (2003 - 2007)

Respondent's Memorandum in Opposition to
Aetna Better Health of North Carolina, Inc.'s
Motion and Memorandum for Leave to Amend
its Petition for a Contested Hearing

Exhibit 11

**A. Jamal Jones
Deposition Excerpts**

IN THE OFFICE OF ADMINISTRATIVE HEARINGS

Optima Family Care of North Carolina,
Inc.,

COUNTY of WAKE

Petitioner,

19 DHR 01959

v.

North Carolina Department of Health
and Human Services, Mandy Cohen M.D.,
MPH in her official capacity as
Secretary of the Department and Dave
Richard in his official capacity as
Deputy Secretary of the Department of
NC Medicaid,

ROUGH DRAFT

Respondents,

and

WellCare of North Carolina, Inc.,
Blue Cross and Blue Shield of North
Carolina, AmeriHealth Caritas of
North Carolina, Inc., Carolina
Complete Health, Inc.,
Respondent-Intervenors.

(Captions continued on page 2)

DEPOSITION OF A. JAMAL JONES

September 30, 2019

Reporter: Wanda B. Constantino, CVR-CM-M
WORDSERVICES, INC.
1102 Driftwood Drive
Siler City, North Carolina 27344
919.548.4914
wanda@mywordservices.com

1 Q. Okay. Mr. Jones, you left the Department in
2 August of 2016, correct?

3 A. Yes, I did.

4 Q. And you -- looking back at Exhibit 425, it appears
5 that you began working with Aetna in September of 2016,
6 correct?

7 A. Yes.

8 Q. Okay. And your position at Aetna is director of
9 business development for Aetna Medicaid, correct?

10 A. Yes.

11 Q. Is that the position that you held when you first
12 started at Aetna in September of 2016?

13 A. Yes.

14 Q. Okay. How did you find out about the director of
15 business development position with Aetna Medicaid?

16 A. I had a couple of different organizations approach
17 me about -- about an opportunity to help build -- to help
18 build Medicaid plans, and I applied for this opportunity.

19 Q. What were the other organizations that approached
20 you to work to build Medicaid plans?

21 A. So the -- at the time United and Gateway
22 approached me in addition to Aetna.

23 Q. When was the first time -- and just a month is
24 fine as a ballpark. What is the first time that you were
25 approached by any of these organizations to come work for

1 Carolina-based Aetna Medicaid employee?

2 A. Yes, to the best of my knowledge.

3 Q. What do you think that you brought to the table
4 for Aetna?

5 A. Knowledge of health systems in North Carolina.

6 Q. When you say "knowledge of health systems in North
7 Carolina," is that from an operational standpoint, from a
8 policy standpoint, both of those standpoints?

9 A. I think it's general knowledge of the overall
10 health system and the health and the -- and organizations in
11 North Carolina.

12 Q. Would that include hospital systems?

13 A. Yes.

14 Q. Would that include community care types of
15 organizations?

16 A. It would include anyone involved in health care in
17 North Carolina.

18 Q. All right. What positions that you held prior to
19 Aetna gave you that knowledge base to work from?

20 A. I think my resume has -- refers -- refers to those
21 positions, so starting both at the -- both at the -- as a --
22 as a hospital administrator and consultant at the
23 association, the Department, and PDA.

24 Q. What -- if you recall, what date did you leave the
25 Department?

1 A. I think it was August 26th. And when I was
2 pulling -- and the reason I had that date specifically was I
3 was pulling that information as part of the subpoena.

4 Q. And what generally were you working on at the
5 Department in the weeks leading up to leaving the
6 Department?

7 A. I -- I the policies and procedures related to the
8 -- the -- moving towards capitation.

9 Q. Okay. What kind of notice did you give the
10 Department about your leaving?

11 A. I don't remember, but it was significant. Three
12 weeks to a month.

13 Q. Okay. And what date did you begin at Aetna?

14 A. September 5th.

15 Q. Did you move any files or paperwork from your
16 office at the Department to your office at Aetna?

17 A. No.

18 Q. Did you move any files or paperwork from your
19 office at the Department to your home?

20 A. No.

21 Q. Was your salary higher or lower at Aetna versus
22 the Department?

23 A. Higher.

24 Q. By how much approximate was it higher?

25 A. 20,000, 30,000 bucks.

Respondent's Memorandum in Opposition to
Aetna Better Health of North Carolina, Inc.'s
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Exhibit 12

**Sheila Brabham Platts
Deposition Excerpts**

IN THE OFFICE OF ADMINISTRATIVE HEARINGS

Optima Family Care of North Carolina, COUNTY of WAKE
Inc.,

Petitioner, 19 DHR 01959

v.

North Carolina Department of Health
and Human Services, Mandy Cohen M.D.,
MPH in her official capacity as
Secretary of the Department and Dave
Richard in his official capacity as
Deputy Secretary of the Department of
NC Medicaid,

Respondents,

and

WellCare of North Carolina, Inc.,
Blue Cross and Blue Shield of North
Carolina, AmeriHealth Caritas of
North Carolina, Inc., Carolina
Complete Health, Inc.,

Respondent-Intervenors.

(Captions continued on page 2)

DEPOSITION OF SHEILA BRABHAM PLATTS

August 23, 2019

Reporter: Cynthia W. Rice, Court Reporter
WordServices, Inc.
1102 Driftwood Drive
Siler City, North Carolina 27344
919.548.4914
wanda@mywordservices.com

1 Director of Provider Operations at the Department.

2 A. Currently I am not.

3 Q. Currently you are not. And what are you doing
4 currently?

5 A. I am currently an employee of Blue Cross Blue
6 Shield of North Carolina.

7 Q. How long have you worked for Blue Cross Blue
8 Shield?

9 A. About six weeks.

10 Q. Why did you make the switch?

11 A. Career advancement and growth opportunity.

12 Q. What was the second thing you said? I'm sorry.

13 A. And growth opportunity.

14 Q. Growth opportunity.

15 A. Yes.

16 Q. So we do have a long table down here --

17 A. Sorry.

18 Q. -- so occasionally you may hear them rattle their
19 sabers about speaking up.

20 A. Okay. Sure.

21 Q. And --

22 MR. KIVUS: My apologies. Can we just have the
23 previous answer read back?

24 MR. PURYEAR: I think it was career advancement
25 and --

1 THE WITNESS: Growth opportunity.

2 MR. PURYEAR: -- growth opportunities.

3 BY MR. PURYEAR:

4 Q. Did Blue Cross Blue Shield seek you out?

5 A. No, they did not.

6 Q. Did you seek them out?

7 A. Yes, I did.

8 Q. Did you see an ad for a particular position?

9 A. Yes, I did.

10 Q. And what position was that?

11 A. It is team lead in product analytics.

12 Q. And is that the position you have?

13 A. Yes, it is.

14 MR. KIVUS: I'm sorry. I just couldn't hear that
15 last part.

16 MR. PURYEAR: She's a team lead, product
17 analytics. And that is the position that she has.

18 MR. KIVUS: Thank you.

19 BY MR. PURYEAR:

20 Q. And you've been in that position for six weeks?

21 A. Yes.

22 Q. And as part of your -- or let me ask this. What
23 are your responsibilities as team leader, product analytics?

24 A. I'm responsible for data reporting.

25 Q. What does that mean?

1 A. I'm responsible for working with customers within
2 the organization to develop reporting tools.

3 Q. As part of your new role at Blue Cross Blue
4 Shield, do you have any interface with their participation
5 in Medicaid managed care in North Carolina?

6 A. No, I do not.

7 Q. Did you go directly from the Division of Health
8 Benefits to Blue Cross Blue Shield?

9 A. Yes, I did.

10 Q. So prior to working at Blue Cross Blue Shield you
11 were the associate director of provider operations for the
12 Department?

13 A. Yes, I was.

14 Q. And I understand you had 25 years' experience in
15 health care-related employment?

16 A. Yes, I do.

17 Q. And tell me a bit about that employment.

18 A. I started out my career as an eligibility worker
19 in South Carolina working with the hospitals. And we were
20 responsible for various eligibility requests for coverage.
21 And I worked primarily at Richland Memorial Hospital working
22 with the patients to help them secure health care coverage
23 to pay for their inpatient hospital stays.

24 Q. And is that -- did you go directly from working
25 with the South Carolina hospitals to working for the

1 set forth.

2 Now, again, if you don't understand my question,
3 feel free to ask me to rephrase. But I want you to
4 understand that unless the Department's attorney
5 specifically instructs you not to answer a question, that
6 you should still answer the question even if, unfortunately,
7 it makes you uncomfortable.

8 Ms. Platts, you've indicated that you worked for
9 the Department of Health and Human Services as the Assistant
10 Director for Provider Services up until about six months
11 ago. Is that correct?

12 A. No, that's not correct. It was actually six -- my
13 last day with the Department was July 12.

14 Q. So six weeks ago. I misheard that because I was
15 trying to understand the calendar if you had done all that
16 implementation work if you left it six months ago. All
17 right. So you left six weeks ago. Thank you for that
18 clarification.

19 Prior to your departure, is it correct to say that
20 your work with the Department involved a lot of interaction
21 with provider, provider representatives, and provider
22 associations?

23 A. Yes.

24 Q. And would your work at the Department of Health
25 and Human Services also involve interactions with private

1 Services?

2 A. Yes.

3 Q. So is it fair to say that the only position that
4 you applied for in the private sector was at Blue Cross Blue
5 Shield of North Carolina?

6 A. As I recall, yes.

7 Q Do you recall what other State agencies you
8 applied?

9 A. I don't recall.

10 Q. What was motivating your interests in looking for
11 opportunities elsewhere?

12 A. Just looking for a different career path.

13 Q. When did you make that decision to start looking
14 for a different career path?

15 A. I don't have a specific time, but I would say in
16 the spring of the year.

17 Q. Was it after you completed this evaluation
18 committee process?

19 A. Yes, it was.

20 Q. Would you say that the process in any way
21 influenced your decision to look for a different career
22 path?

23 A. No, it did not.

24 Q. So, then, what did influence your decision?

25 A. As I stated previously, just looking for a

1 Q. Other than just the HR person telling you to talk
2 with the attorneys, did you have any other conversations
3 with anybody else at Blue Cross Blue Shield of North
4 Carolina?

5 A. And I notified my manager and my peer that I would
6 be at a deposition today, so my work area would be covered.

7 Q. That was very responsible of you to do that, and
8 you anticipated my next question. So you are, I'm assuming,
9 a salaried employee of Blue Cross Blue Shield of North
10 Carolina?

11 A. Yes, I am.

12 Q. And so is it fair to say that Blue Cross Blue
13 Shield of North Carolina is paying you to be here today?

14 A. Yes. I'm on paid time off at this point.

15 Q. When you -- when did you apply for the Blue Cross
16 Blue Shield of North Carolina position? You said you
17 started it about six weeks ago. I'm assuming that you had
18 to apply before you started. When did you apply?

19 A. I do not know the exact date. I would say
20 somewhere in the timeframe of May to -- probably around the
21 May timeframe, May to June, early June.

22 Q. So just to get our bearings straight, that was
23 after the awards were announced, and when you-all were in
24 the beginning stages of implementation. Is that correct?

25 A. You are correct.

Respondent's Memorandum in Opposition to
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Exhibit 13

Deposition Exhibit 427

Evaluation Question	
11.	<p>The Department is seeking partners to create a more competitive insurance environment in North Carolina and increase access to health care across family units. The Offeror may choose, at its sole discretion, to indicate its commitment to offer Qualified Health Plans (QHPs) in North Carolina on the Federally Facilitated Marketplace (FFM) in QHP Plan Year 2021. Commitment to offer QHPs on the FFM is defined as timely submitting all necessary NCDOL-related regulatory submissions (including rates and policy forms) and QHP application to the FFM in the Spring of 2020 (or within whatever time frames NC DOI and the FFM establish), and committing to actively seek all required state and federal approvals to offer QHPs.</p> <p>The Offeror may choose to indicate its commitment to participating in the FFM by outlining current Marketplace participation in North Carolina and other states and expected FFM footprint in North Carolina in 2021.</p> <p>A commitment to offer QHPs in North Carolina on the FFM is optional and, if made, worth bonus points. An Offeror which does not make this commitment would not be awarded bonus points.</p>
Response	
This evaluation question is not applicable to Aetna.	
Detail any limitations and / or issues meeting the Department's expectations or requirements related to this response. No response will be interpreted as no limitations or issues.	



Respondent's Memorandum in Opposition to
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Exhibit 14

Deposition Exhibit 430

HUNTON ANDREWS KURTH

HUNTON ANDREWS KURTH LLP
BANK OF AMERICA PLAZA
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FILE NO: 011168.0000015

March 5, 2019

VIA OVERNIGHT DELIVERY	VIA HAND/SPECIAL DELIVERY
PROPOSAL NUMBER: 30-190029-DHB Attn: Kimberley Kilpatrick Department of Health and Human Services Division of Health Benefits 820 S. Boylan Ave. McBryde Building, Office 462 Raleigh, NC 27603	PROPOSAL NUMBER: 30-190029-DHB Attn: Kimberley Kilpatrick Department of Health and Human Services Division of Health Benefits 820 S. Boylan Ave. McBryde Building, Office 462 Raleigh, NC 27603

RE: Notice of Protest and Request for Protest Meeting, and Request for Stay

**State of North Carolina Department of Health and Human Services, Division of
Health Benefits, RFP #30-190029-DHB Prepaid Health Plan Services**

Dear Ms. Kilpatrick:

We represent Aetna Better Health of North Carolina Inc., d/b/a Aetna Better Health of North Carolina ("Aetna"), with regard to RFP #30-190029-DHB (the "RFP"). Pursuant to Section II.G.6 of the RFP and the North Carolina Administrative Code, 01 NCAC 05B.1519, Aetna hereby respectfully submits this Notice of Protest and Request for Protest Meeting ("Protest").

Aetna is grateful for the opportunity to be heard in connection with the RFP, which seeks to carry out the worthy goals of the North Carolina legislature in directing the transition of Medicaid from a predominantly fee-for-service structure to managed care. Aetna understands the hard work, complexity, and effort involved in making a final determination with respect to the RFP, and appreciates the Department and its leadership for the work it has already put into this ongoing movement to managed care.

As this is North Carolina's first foray into managed care, it is of the utmost importance to the State and its intended beneficiaries that the best and most qualified entities be selected, even if it



Ms. Kimberley Kilpatrick

March 5, 2019

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requires the reconsideration of scoring and proposals where scoring errors or oversights have occurred, or where certain Offerors have failed to properly respond or disclose material information in their respective proposals. Indeed, in the present case, because the margin between the scoring for the top five statewide Offerors is razor-thin, it becomes even more imperative to ensure that any and all discrepancies and errors be carefully reviewed, considered, and corrected, before implementation of any Contract Awards goes forward.

It is with this in mind that Aetna protests its omission as the recipient of a statewide Prepaid Health Plan (PHP) contract, and the resulting award of PHP contracts announced on February 4, 2019, for the following reasons:

1. Aetna did not receive proper credit for responsive answers to RFP questions, as measured against similar or less complete or inadequate answers provided by other Offerors. The correction of these errors results in Aetna being in the top four statewide Offerors, irrespective of the need to adjust other Offerors' scores downward or address grounds for the disqualification of successful Offerors;
2. AmeriHealth Caritas ("AmeriHealth") was improperly awarded points for inadequate and incomplete answers to RFP questions, that, if corrected, are in of themselves sufficient to place AmeriHealth outside of the top four statewide Offerors and Aetna into the top four Offerors; and,
3. WellCare of North Carolina, Inc.'s ("WellCare") proposal is flawed and should be disqualified because it noticeably failed to disclose sanctions imposed within the last seven (7) years as required by Question 10 of the RFP, and also failed to disclose corrective actions taken to prevent any future occurrences of the problems that led to those sanctions, as required by Question 10 of the RFP.

For the foregoing reasons, discussed in greater detail below, Aetna respectfully requests that, in light of the present statutory limit on the number of statewide contracts that may be awarded pursuant to the RFP, the Department revise the scores and rankings accordingly, disqualify WellCare, and award Aetna a statewide PHP contract. Based on the record before it, Aetna respectfully submits that the awards as they currently stand are, among other things, unsupported by substantial evidence, arbitrary and capricious, and if not corrected, the result of an abuse of discretion. *See* N.C. Gen. Stat. § 150B-51.

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Alternatively, Aetna requests such other relief as may be necessary to remedy the issues raised in this Protest, as may be amended and supplemented, including, if necessary, re-evaluation and/or re-procurement.

Aetna further requests that the award and/or implementation of the PHP contracts be stayed pending the outcome of this Protest and any other proceedings that may be had regarding this matter. Such a stay is dictated by fundamental fairness, so that the issues herein can be addressed in a fair, orderly and timely manner without creating market and member confusion.

GROUND AND REASONS FOR THE PROTEST

- 1. Aetna did not receive proper credit for its answers to certain RFP questions, as measured against similar, less complete, or inadequate answers provided by other Offerors, and it should be granted a positive adjustment of no less than 18.66075 points to its total score.**

In a number of instances, Aetna did not receive scores for responsive answers to RFP questions that were commensurate with or superior to those of other Offerors who gave similar, less complete, or less adequate answers to evaluation questions. Some of these errors are sufficiently manifest on their face and, if not corrected, lead to an arbitrary and capricious result, which is unsupported by substantial evidence. When corrected, Aetna places in the top four statewide Offerors.

The scoring gap between the top-five Statewide Offerors, only four of which are currently eligible for contract awards, is indisputably narrow:

Offeror Name	Weighted Total Points
WellCare Health Plans	736.19304
United Health Care	727.76474
BCBSNC - Healthy Blue	712.22431
AmeriHealth Caritas North Carolina	706.66204
Aetna	704.60144

Based on the scoring issues discussed below, the appropriate correction of these scores places Aetna in the top four Statewide Offerors.

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- a. Aetna should be awarded an additional 2.16 points for its answer to Question No. 5, which would raise its total score to 706.76144.**

Attachment O.11, Question 5 required that:

The Offeror shall provide information requested in *Attachment O. Offeror's Proposal and Response Table 3: Entities performing core functions or with proposed experience* for each entity, including parent entities, subcontractors, partners, subsidiaries, and any other individual or organization:

- a. That will perform Core Medicaid Operational Functions, as defined in the Contract, for the Offeror under the Contract; and
- b. Whose experience has been provided by the Offeror for consideration by the Department for the purposes of this RFP and Contract award, including all entities with experience referenced in responding to the RFP evaluation questions?

The Offeror shall be fully transparent in describing the experience of the entity and shall include all experience, both positive and negative, related to the entity's role(s) or responsibilities. The Department may exercise, at its sole discretion, in the PHP RFP evaluation process, whether or not to consider the experience or to what extent the experience applies for entities not performing core functions.

Offeror must fill out 1 table for each entity, including parent entities, subcontractors, partners, subsidiaries, and any other individual or organization that meet the criteria listed in 5.a. and/or 5.b. Completed tables shall not be counted toward the Offeror's total page guidelines.

There are several components to Question No. 5 for which Aetna did not receive full credit for its answers, as can be objectively determined by reference to proposals that received higher scores for responses that were, at a minimum, the same or substantively indistinguishable from Aetna's responses. The resulting scoring errors, which included Aetna getting a lesser amount of credit for the exact same experience and using the same vendors as those Offerors receiving higher scores, include as follows:

- **(Question 5):** WellCare's PBM, "CVS," is the same PBM being used by Aetna ("Caremark"). On Aetna's scoresheet Caremark receives an "Exceeds" mark for

Ms. Kimberley Kilpatrick

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experience – while on WellCare's scorecard CVS PBM (the same company) receives a "Substantially Exceeds" for experience. (*Compare Consensus Scoring Document*, Aetna Score at p. 2 of 18, with WellCare Score, at p. 2 of 20; Ex. 1, Aetna Proposal Excerpts, Q.5, pg. 8; Ex. 2, WellCare Proposal Excerpts, Q.5, pg. 26). Aetna's rating here should be changed from "Exceeds" to "Substantially Exceeds."

Additional points to be awarded Aetna: **0.405**

- **(Question 5):** Aetna's Subcontractor, eviCore healthcare MSI, LLC ("eviCore"), was rated "Exceeds" for Experience on Aetna's scorecard. However, eviCore was rated "Substantially Exceeds" on United's scorecard. This is the same company and should receive the same experience score. (*Compare Consensus Scoring Document*, Aetna Score at p. 2 of 18, with UnitedHealthcare Score at p. 2 of 22; Ex. 1, Aetna Proposal Excerpts, Q.5, pg. 15; Ex. 3, UnitedHealthcare Proposal Excerpts, Q.5, pg. 24). Aetna's rating here should be changed from "Exceeds" to "Substantially Exceeds."

Additional points to be awarded Aetna: **0.405**

- **(Question 5):** Aetna's Subcontractor, Partners BH was rated "Meets" for experience, whereas all other bidders received "Exceeds" for any LME/MCO partners, with justification notes indicating because they are LME/MCO. Moreover, the evaluation sheets incorrectly labels Partners BH as "Aetna Partners," indicating that the Evaluation team missed the identification of Partners BH as being an LME-MCO like each of the PHPs that received "Exceeds." (*Compare Consensus Scoring Document*, Aetna Score at p. 2 of 18, with Ex. 1, Aetna Proposal Excerpts, Q.5.1, pg. 19; Ex. 3, UnitedHealthcare Proposal Excerpts, Q.5.1, p. 33; Ex. 2, WellCare Proposal Excerpts, Q.5.1, pp. 40-43). Aetna's rating here should be changed from "Meets" to "Exceeds."

Additional points to be awarded Aetna: **0.675**

- **(Question 5):** Aetna's subcontractor, Aetna Medicaid Administrators, was identified in its Proposal as having 30 years-experience in 15 states. Other bidders' subcontractors listing a similar level of experience received "Exceeds" scores consistently, and Aetna should have also received a rating of "Exceeds." (*See Ex. 1, Aetna Proposal Excerpts, Q.5.1, pg. 5; compare Consensus Scoring Document, Aetna Score, at p. 2 of 18; with*

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BCBS Score, at p. 2 of 18; UnitedHealthcare Score, at p. 2 of 22). Aetna's rating here should be changed from "Meets" to "Exceeds."
Additional points to be awarded Aetna: **0.675**

These corrections necessary to address each of the scoring errors identified above should result in a cumulative net **2.16 point increase** to Aetna's total score.

- b. Aetna should be awarded an additional 10.5 points for its answer to Question No. 46, which would raise its total score to 717.26144.**

Attachment O.11, Question No. 46 required that:

The Offeror shall confirm its adherence and describe its approach to meeting the Department's expectations and requirements for Value Based Payments stated in *Section V.E.2. Value Based Payments/Alternative Payment Models*, including a description of the PHP's approach to ensuring payments to Providers are increasingly focused on population health, appropriateness of care and other measures related to value. The Offeror shall also include a description of its IT infrastructure and how that system will support moving toward value-based payment, including shared savings and/or risk-sharing across different provider types, care settings and locations. The Offeror shall detail any limitations and/or issues with meeting the Department's expectations or requirements. The response shall include:

- a. A description of value-based payment arrangements the Offeror has used in **up to 2 other locations** (e.g., another state or region). ...

[Emphasis added].

Aetna was unfairly prejudiced when the Evaluation Committee rewarded Offerors who violated the express instructions of Question No 46 with additional points. The RFP could not have been clearer that the number of locations Offerors were permitted to discuss – two – was a ceiling, not a floor. Aetna complied, even though, as a nationwide leader in value-based reimbursement, Aetna has numerous value-based contract arrangements that could have been shared in response to Question No. 46, but were not because it followed the instructions.

In contrast, other Offerors simply ignored the Department's instructions, yet were rewarded for doing so. For example, although its response is significantly redacted, AmeriHealth identified at

least five (5) locations in its response (D.C., Louisiana, and Pennsylvania in Section A, and also identifying Michigan and Florida in Section D), and was awarded a rating of "Exceeds" for its disregard. (*See* Consensus Scoring Document, AmeriHealth Score, at p. 11 of 16). BCBSNC also heavily redacted its response, but plainly flouted instructions by leveraging all twenty-two (22) of its Medicaid plans in its response, and similarly received an "Exceeds." (*See* Consensus Scoring Document, BCBSNC Score, at p. 14 of 18).

Aetna, on the other hand, was punished for its compliance by receiving a rating of "Meets." (*See* Consensus Scoring Document, Aetna Score, at p. 15 of 18). It is hard to escape the conclusion that had Aetna similarly disregarded instructions and relied on its experience in more than two locations, it would have readily been able to further demonstrate its entitlement to a rating of "Exceeds" or "Substantially Exceeds." As its answer stands, Aetna already deserves a rating of at least "Exceeds" because of the quality of its two examples offered in adherence to the RFP's express ceiling. Aetna certainly should not be penalized for following the rules.

Accordingly, Aetna should at least receive an additional **10.5 point increase** to its total score for its response to Question No. 46.

- c. Aetna should be awarded an additional 4.59375 points for its answer to Question No. 48, which would raise its total score to 721.85519.**

Attachment O.11, Question 48 required that:

The Offeror shall confirm its adherence and describe its approach to meeting the Department's expectations and requirements stated in *Section V.F.2. Engagement with Community and County Organization*. The Offeror shall detail any limitations and/or issues with meeting the Department's expectations or requirements. The response shall include:

- a. Approach to design and implement Local Community Collaboration Strategy;
- b. Prior experiences supporting and working with communities and community-based organizations and implementing a similar strategy that the Department is looking to implement through the Contract;

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c. Considerations for magnitude of the state/number of county and community based services while remaining cost effective; and

d. Approach to reducing burden on agencies/partners.

PROVIDE SUPPORTING DOCUMENTATION (not part of page count):

1. Offeror's draft Community and County Engagement Plan that demonstrates an understanding of the North Carolina Medicaid and NC Health Choice program, the state's geographic and cultural diversity and the different types of community of agencies engaged with Members.

Aetna should receive an additional **4.59375 points** for its answer to Question No. 48, because it arbitrarily received a rating of "Meets," despite a clearly superior response to that of WellCare which received a rating of "Exceeds."

Aetna's response to Question No. 48 is not only more robust and thoughtful, it is objectively superior to that of WellCare. Notably, Aetna met with **1,000** Community Based Organizations (CBOs) in all 100 counties in North Carolina throughout the past 2 years, and:

- Engaged in extensive efforts in North Carolina to tackle the opioid crisis
- Proposed a Community Health Worker Pilot
- Supported schools with Jobs for America's Graduates (JAG) program
- Provided monetary donations for hurricane relief and food insecurity
- Hosted focus groups that informed value adds
- Proposed co-location of staff in CBOs
- Partnered with Community Care of North Carolina, a known entity in all of the regions of the State
- Proposed maintaining a housing specialist on staff at the plan to help with housing related issues

(See Ex. 4, Aetna Proposal Excerpts, Q.48, at pp. 618-626).

In contrast, WellCare met with only 200 CBOs, and:

- Talked about their proprietary Community for Impact Model - Community Advocate
- Provided monetary donations for hurricane relief
- Had a named North Carolina CEO
- Proposed local community relations workers

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- Agreed to be on an advisory council

(See Ex. 5, WellCare Proposal Excerpts, Q.48, at pp. 511-517).

At a minimum, Aetna should receive a score equal to that of WellCare, resulting in a **4.59375 point** increase in its total score.

- d. Aetna should be awarded an additional 1.407 points for its answer to Question No. 56, which would raise its total score to 723.26219.**

Attachment O.11, Question 56 required that:

The Offeror shall confirm its adherence and describe its approach to meeting the Department's expectations and requirements outlined in *Section V.H.2 Encounters*. The Offeror shall detail any limitations and/or issues with meeting the Department's expectations or requirements. The response shall include:

- a. Performance management strategies to ensure complete, accurate and timely encounter data submissions are made to the Department;
- b. Demonstrated understanding of the importance of accurate, complete and timely Medical and Pharmacy encounter data to the Department for use in the North Carolina Medicaid and NC Health Choice programs. In addition, Offeror shall specifically include steps to support drug rebates and steps to support capturing all applicable diagnosis information on encounters to support risk adjustment;
- c. Operating model including staffing to support the encounter development and submission process;
- d. Approach to reference data and how the Offeror shall integrate the Department's reference data into the Offeror's encounter generation process;
- e. Performance management strategies for achieving the Department's required timely, accuracy and completeness rates;
- f. Description of the Offeror's past performance in complying with encounter submission SLAs for other Medicaid customers including the acceptance rates as percentages;

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g. Leading practices it has adopted to improve data quality in encounter submission, include applicable policies and procedures and the Offeror's use of the Post Adjudicated Claims Data Reporting (PACDR) version of the X12 837 transaction;

h. Procedure to work with providers and internal operations in correcting Encounter errors; and

i. Describe the challenges and associated mitigation approaches with encounter data submission (including managing denied claim submission, duplicate submissions, sub capitated claims, value-based arrangements, or non-traditional services such as ILOS, value-added services, health-related resources) and specific steps taken to remediate issues. Include specific data on outcomes achieved.

PROVIDE SUPPORTING DOCUMENTATION (not part of page count) to include a Draft Encounter Implementation Approach.

Aetna should also receive an additional **1.407 points** for its response to Question 56, because the grounds for reducing its score were arbitrary and capricious. Aetna was assigned "0" points for "Supporting Documentation" on the *Draft Implementation Approach* for not specifically addressing items in Section V.K.6.c. (See Consensus Scoring Document, Aetna Score at p. 15 of 18).

The question requested Offerors to specifically respond to V.H.2, not V.K.6.c. Aetna nevertheless actually – and properly – addressed V.K.6.c elements in its Question 56 Narrative. Aetna thus provided a complete and fulsome response to Question 56, and there was no basis for granting it "0" points for the Supporting Documentation Requirement. (See Ex. 6, Aetna Proposal Excerpts, Appendix R; Ex. 7, Aetna Proposal Excerpts, Q.56 & Scope of Services, V.H.2, pp. 224-230 & V.K.6.c, p. 221).

Because Aetna should at least receive a "Meets" rather than a "Does Not Meet" with respect to this issue, it should receive, at a minimum, an additional **1.407 points** to its total score.

e. The Corrections to Aetna's Score, Standing Alone, Place it in the Top Four Statewide Offerors.

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As demonstrated above, Aetna should have received a total of 18.66075 additional points. As a result, Aetna's total score should have been 723.26219 which would put it in the top four Statewide Offerors:

Offeror Name	Weighted Total Points	Corrected Weighted Total Points
WellCare Health Plans	736.19304	
United Health Care	727.76474	
Aetna	704.60144	723.26219
BCBSNC - Healthy Blue	712.22431	
AmeriHealth Caritas North Carolina	706.66204	

Thus, the errors in evaluating Aetna's proposal – standing alone – are sufficient to sustain this Protest. But additional errors made in favor of fourth-place finisher AmeriHealth Caritas provide additional grounds for this Protest.

- 2. AmeriHealth was improperly awarded points for inadequate and incomplete answers to RFP questions, and it should receive a negative adjustment of no less than 34.18973 points to its total score.**

Fourth-place finisher AmeriHealth received scores for answers to RFP questions that were incomplete or facially inadequate, and if not corrected, lead to an arbitrary and capricious result. When corrected, this places Aetna in the top four statewide Offerors, and AmeriHealth in fifth place, unless WellCare is disqualified for the reasons discussed separately herein.

- a. AmeriHealth's score for Question No. 50 should be reduced by 4.4625 points, which would reduce its total score to 702.19954.**

Attachment O.11, Question 50 required that:

The Offeror shall confirm its adherence and describe its approach to meeting the Department's expectations and requirements outlined in *Section V.G.1. Service Lines*. The

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Offeror shall detail any limitations and/or issues with meeting the Department's expectations or requirements. The response shall include:

- a. Approach to ensure all pharmacy prior authorization requests are processed within 24 hours;
- b. Experience, approach and policies with operating a behavioral health crisis line;
- c. Approach to customizing and training Member Service and provider relations staff on North Carolina Medicaid Managed Care program and providing specific responses to potential customer service inquiries; and
- d. Process to integrate the Nurse Line into the Offeror's Care Management and health care delivery model.

In scoring Question 50, AmeriHealth's response was rated as "Exceeds," whereas Aetna's response was rated "Meets" despite the fact that Aetna's response was at a minimum, equivalent to AmeriHealth's response and in one critical respect was objectively superior to AmeriHealth's response. (*Compare* Consensus Scoring, Aetna Score, at p. 3 of 18, with AmeriHealth Score, at p. 3 of 16; Ex. 8, Aetna Proposal Excerpts, Q.50, pp. 633-638; Ex. 9, AmeriHealth Proposal Excerpts, Q.50, pp. 319-324).

While the Evaluator comments listed in Column C for AmeriHealth apply equally to Aetna, as both proposals provide for: (a) live person access 24/7/365; (b) warm transfers; and (c) mental health first aid training, Aetna's response was superior to that of AmeriHealth because AmeriHealth failed to comply with the RFP requirement dictating that Emergency Member issue service lines must be located in North Carolina. Section V, Scope of Services, page 214, V.G. Table 1 indicates Emergency Member issues service line is required to be ***in the State of North Carolina***. (See Ex. 10, RFP excerpt, p. 214). Aetna properly responded that its after-hours service will be in North Carolina (Aetna Proposal Excerpts, Q.50, p. 634). In contrast, AmeriHealth's proposal provides that their after-hours will be located ***in Philadelphia, Pennsylvania*** – not North Carolina. (Ex. 9, AmeriHealth Proposal Excerpts, p. 319).

Thus, while AmeriHealth's response should, at a minimum, be downgraded to "Meets," resulting in a **1.3125 reduction** to its total score, it should more appropriately be scored as a "Does Not

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Meet,” in light of its failure to comply with the requirement that its service line be in the State of North Carolina, resulting in a **4.4625 reduction** to its total score.

- b. AmeriHealth’s score for Question No. 62 should be reduced by 5.95 points, and its corresponding score for Question No. 5 and 9 should be reduced by 3.77723 and 20.0 points respectively, which would reduce its total score to 672.47231.**

Attachment O.11, Question 62 required that:

The Offeror shall confirm its adherence and describe its approach to meeting the Department's expectations and requirements outlined in *Section V.J.3. Fraud, Waste and Abuse Prevention*. The Offeror shall detail any limitations and/or issues with meeting the Department's expectations or requirements.

a. Examples (up to three) of initiatives to proactively prevent fraud/waste/abuse previously enacted and the outcomes achieved; include any work with law enforcement in criminal or civil prosecution fraud cases.

b. Approach to design and uphold a proactive fraud prevention, detection and referral process. Include both internal and external policies and procedures.

c. Staffing model for the SIU and how the SIU would work with state or federal investigators.

d. Description of how the Offeror will work with the Department, MID or the OIG to investigate and prosecute potential fraud/waste/abuse.

e. Description of how the Offeror will balance the tensions between paying Providers timely and accurately with the Offeror’s responsibility:

i. To monitor potential fraud/waste/abuse; and

ii. Cost avoidance and cost recovery.

PROVIDE SUPPORTING DOCUMENTATION (not part of page count) to include the Offeror’s draft Fraud, Waste and Abuse Plan.

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List all Entities identified in Question #5 of the Offeror's Proposal and Response that are performing core functions or proposed experiences related to this response.

AmeriHealth's response to Question No. 62 is a house built on sand, because it is premised on AmeriHealth's reliance on vendors for whom it failed to make necessary and critical disclosures. As such, its response not only fails to meet the requirements of Question No. 62, but also provides grounds for a reduction in AmeriHealth's score for Question No. 5, and other questions in the RFP relating to Question No. 5.

Question No. 62 requires Offerors to list all entities identified in Question No. 5 as performing core functions related to their responses to Question No. 62. In its narrative response to Question No. 62, AmeriHealth discussed the significant role of two vendors, Optum and Change Healthcare Coding Advisor, whose role will be to monitor payments and overpayments. The functions performed by these vendors fall squarely within the definition of Core Medicaid operations functions, which include processing and payment of claims. (Section V (Scope of Services) of the RFP, at p. 6 of 221); *see also*, Section V.H. of the RFP, at p. 189 of 221; and Section V.J.2.a, at p. 203 of 221). Yet, AmeriHealth failed to disclose either of these vendors in response to Question No. 5, nor did they list either of these vendors at the outset of Question No. 62 as expressly required by the instructions. (*See* Ex. 11, AmeriHealth Proposal Excerpts, Q.62, pp. 380, 383-384; Ex. 12, AmeriHealth Proposal Excerpts, Q.5).¹

As such, a reduction of AmeriHealth's score is warranted because:

- (i) by failing to properly list these entities in Question No. 5 and Question No. 62, AmeriHealth's reliance on them in response to Question No. 62 should be disregarded, thereby rendering this response inadequate;

¹ Question No. 10, for which AmeriHealth's response is entirely redacted (and was already rated as only "Partially Meets"), also required disclosures for entities identified in Response to Question No. 5, so it is reasonable to assume that the failure to respond with respect to these entities extends to that question. It also appears that AmeriHealth omitted these vendors in its responses to Questions No. 45 and 55. Aetna is unable at this time to assess the full extent to which further point reductions are warranted with respect to these related issues.

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(ii) by failing to disclose these entities in the first place in response to Question No. 5, AmeriHealth failed to make required disclosures in that response necessary for the Department to fully and fairly evaluate AmeriHealth's Proposal; and,

(iii) by failing to disclose these entities in response to Question No. 5, AmeriHealth further failed to make complete disclosures as to these entities in response to Question No. 9.

Accordingly:

- (i) With respect to Question No. 62, AmeriHealth received an equal score (5.95) ("Exceeds") to Aetna, UnitedHealthcare, and WellCare. (*Compare* Consensus Scoring, AmeriHealth Score, at p. 13 of 16, with Aetna Score, at p. 15 of 18, UnitedHealthcare Score, at p. 19 of 22, and WellCare Score, at p. 17 of 20). Because its reliance on Optum and Change Healthcare Coding Advisor should be disregarded with respect to Question No. 62, AmeriHealth should be scored as "Does Not Meet" and awarded no points for its response to Question No. 62, resulting in a **5.95 point reduction** to its total score.
- (ii) AmeriHealth's score for its response to Question No. 5 should be downgraded to "Does Not Meet" as to these two entities, as a result of failing to identify them as performing Core Medicaid functions and providing the information required of them by Question No. 5, resulting in an **additional 3.77723 point reduction** to its total score.
- (iii) In addition to the disclosures directly required by Section 5, other sections of the RFP required full disclosures from entities performing Core Medicaid functions, which AmeriHealth thus additionally and necessarily failed to address with respect to Optum and Change Healthcare Coding Advisor, including, without limitation, Question No. 9, resulting in an **additional 20.0 point reduction** to its total score.

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Taken together, the defects described above with respect to these interrelated issues should result in a **29.72723 point reduction** in AmeriHealth's total score.²

c. The Corrections to AmeriHealth's Score, Standing Alone, Drop it Below Aetna and therefore Place Aetna in the Top Four Statewide Offerors.

Standing alone, the correction of AmeriHealth's Score places Aetna in the Top Four Statewide Offerors, and AmeriHealth in fifth place, unless WellCare is disqualified for the reasons discussed herein.³ When combined with the corrections to Aetna's score, however, the correct result is even more manifest:

Offeror Name	Weighted Total Points	Corrected Weighted Total Points
WellCare Health Plans	736.19304	
United Health Care	727.76474	
Aetna	704.60144	723.26219
BCBSNC - Healthy Blue	712.22431	
AmeriHealth Caritas North Carolina	706.66204	672.47231

² Aetna notes that there are additional similar deviations with respect to AmeriHealth's failure to list vendors/subcontractors at the outset of their responses to RFP questions that required them to do so, where such responses discussed vendors/subcontractors identified as performing core functions in Question No. 5. For example, AmeriHealth discussed Cotiviti and HMS as part of their response to Question No. 55, but did not list them as entities performing core functions at the outset of that response (despite listing them in Question No. 5). Similarly, in Question No. 62, AmeriHealth discusses using PerformRx for fraud, waste and abuse issues involving pharmacy claims, but did not list it as an entity performing core functions at the beginning of that response (again, despite listing it in Question No. 5). Aetna at this time has not been able to determine the impact that these additional defects should have on AmeriHealth's total score.

³ In addition to the issues discussed above, Aetna objects to the award of bonus points to AmeriHealth for its "commitment" to participate in Qualified Health Plans in North Carolina on the Federally Facilitated Marketplace (the "FFM"), particularly where, even without the scoring requested corrections requested herein, Aetna outscored AmeriHealth on its Medicaid proposal, and AmeriHealth is not presently participating in the FFM in North Carolina.

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3. WellCare's Proposal should be rejected and disqualified for its failure to disclose Sanctions and Corrective Actions in response to Question 10 of the RFP.

In 2015, WellCare of Iowa, Inc. was disqualified from an award of an Iowa Medicaid Contract, and its contract was terminated, as a result of its failure to disclose events that WellCare has once again improperly failed to disclose, namely:

- sanctions imposed by a Settlement Agreement effective March 23, 2012 (attached hereto as **Exhibit 13**; see ¶¶ 1, 31, and p. 29) between the United States, through the U.S. Department of Justice, and WellCare Health Plans, Inc. and various WellCare affiliates; and,
- corrective actions imposed on it by a Corporate Integrity Agreement (CIA) (attached hereto as **Exhibit 14**).

The Settlement Agreement arose out of several lawsuits filed by Relators (as defined in the Settlement Agreement) against numerous WellCare affiliates pursuant to the *qui tam* provisions of the False Claims Act, 31 U.S.C. § 3730(b), which included claims relating to false claims submitted for payment to the Medicaid Program.

In ruling that WellCare should be disqualified, the Administrative Law Judge ("ALJ") specifically concluded that:

- the Settlement Agreement and the \$137.5 million payment to resolve false claim litigation and avoid suspension from the Medicaid program was "**a penalty**" and "**a monetary sanction**" within the applicable look-back period; and,
- the CIA, in force through April 2016, required WellCare to take corrective actions to prevent repetition of past misconduct.⁴

⁴ As the Administrative Law Judge's Proposed Decision explains: "A Corporate Integrity Agreement (CIA) is a document that outlines the obligations an entity agrees to as part of a civil settlement. OIG negotiates CIAs with health care providers and other entities as part of the settlement of Federal health care program investigations arising under a variety of civil false claims statutes. Providers or entities agree to the obligations, and in exchange, OIG agrees not to seek their exclusion from participation in the Medicare, Medicaid or other federal health care programs. Further information about CIAs is available through the OIG website, at: <http://oig.hhs.gov/faqs/corporate-integrity-agreements-faq.asp>." (Ex. 16, Proposed Decision, p. 27, fn. 15).

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(See Iowa Department of Inspections and Appeals, Division of Administrative Hearings, Appeal Nos. 16001573, 16001590, 16001623, Proposed Decision, at pp. 41-42 (attached hereto as **Exhibit 16**).

Because the ALJ fittingly found that these sanctions and corrective actions were within the applicable look-back period, and WellCare failed to disclose them, the Iowa Department of Human Services accordingly determined that: **“The Notice of Intent to Award is REVERSED as to WellCare of Iowa, Inc. and its contract with DHS is terminated.”** (See Final Decision, attached hereto as **Exhibit 15**).⁵

The same analysis inescapably applies here, because WellCare has again failed to disclose the Settlement Agreement and the CIA despite the express disclosure requirements of this RFP.

Question 10 in the present RFP required Offerors to disclose all sanctions imposed against the Offeror as part of a managed care contract in the past seven years, as well as any corrective actions taken to prevent any future occurrence of the problem leading to the sanction(s). Section VIII, Attachment O, Question 10, required that:

The Offeror shall disclose all sanctions imposed against the Offeror as part of a managed care contract in the past seven (7) years in the *Attachment O. Offeror’s Proposal and Response Table 6: Disclosure of Imposed Sanctions as part of a Managed Care Contract in Past 7 Years*. For the purposes of this question, a sanction shall include any monetary penalty, including e.g., civil monetary penalty or liquidated damage. The Offeror’s response shall include information for the Offeror as well as all entities identified as performing a Core Medicaid Operations Function in Question #5.

a. If imposed, describe the nature of the sanction, the underlying action leading to the sanction, the market in which the sanction was imposed, and the assessed monetary amount (if applicable).

b. Describe any corrective actions taken to prevent any future occurrence of the problem leading to the sanction(s).

c. If the sanction(s) was the subject of an administrative proceeding or litigation, indicate the result of the proceeding/litigation.

⁵ The Iowa Department’s Final Decision, in turn, was upheld in the Iowa District Court of Polk County. See *WellCare of Iowa, Inc., et al. v. Iowa Department of Human Services*, Case No. CVCV051022, Ruling on Petition for Judicial Review, p. 13 (attached hereto as **Exhibit 17**).

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Offeror must fill out 1 table for each imposed sanction. Completed tables shall not be counted toward the Offeror's total page guidelines.

Question 10 and subsection (a) required Offerors to disclose sanctions for themselves and for entities identified in Question 5 as performing a Core Medicaid Operations Function, which included Comprehensive Health Management, Inc., a WellCare affiliate that was expressly identified as party to the Settlement Agreement. (See Ex. 18, WellCare Proposal Excerpts, Q.5; Ex. 13, Settlement Agreement, p. 1). Therefore, as it was an entity named in Question No. 5 as performing a Core Medicaid Operations Function and an entity that was a party to the Settlement Agreement, WellCare of North Carolina was expressly required to disclose any sanctions against Comprehensive Health Management, Inc. in responding to Question 10, including, without limitation, the \$137.5 million Settlement Agreement, which falls squarely within the seven (7) year lookback period of Question No. 10.

But WellCare failed to do so. (See Ex. 18, WellCare Proposal Excerpts, Q.10).

This is even more egregious, because in response to Question 10, WellCare discussed other (less critical) sanctions against various entities who were also parties to the Settlement Agreement, including, WellCare of Georgia, Inc., WellCare of Florida, Inc., Harmony Health Plan of Illinois, Inc., WellCare Health Plans, Inc., and WellCare of Ohio, Inc. (Compare Ex.13, Settlement Agreement, p. 1 with WellCare Proposal Excerpt, pp. 108 *et seq.*). But again, no mention of the \$137.5 million Settlement Agreement. This cherry-picking is simply inexcusable and renders WellCare's response and its Proposal misleading at best.

In addition to failing to disclose the Settlement Agreement in response to Question 10(a), WellCare further failed to disclose the corrective actions required by the CIA – which expressly served as consideration for the Settlement Agreement – as required by Question 10(b). (See Ex. 18, WellCare Proposal Excerpts, Q.10; Ex. 13, Settlement Agreement, at ¶ 5; Ex. 14, CIA). The CIA was binding on all WellCare affiliates, yet here again, no disclosure.

Both the Settlement Agreement and the CIA should have been fully disclosed in response to Attachment O, Question 10, and WellCare's Proposal should be accordingly rejected as misleading and incomplete.⁶ Yet, WellCare's failure to disclose this information resulted in

⁶ It should also be noted that WellCare may also have been required to disclose this and possibly other information relating to it in response to Attachment 5 (Offeror's Client References) of the RFP, and Attachment O, Form 9 (which was subject to redaction by WellCare). Aetna reserves the right to supplement this Protest as more information regarding these responses becomes available.

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WellCare receiving points that were not appropriate. This profound failure calls into question, at best, WellCare's attention to detail and, at worst, its credibility. Pursuant to RFP § II.E.1.b, "Offeror's proposal must clearly demonstrate compliance with all the requirements stated within this RFP." The Department similarly reserves the right to reject proposals deemed incomplete, non-responsive, or non-compliant with the RFP requirements; or when such rejection is deemed to be in the best interest of the Department or the State of North Carolina. Moreover, the failure to complete and return all documents and attachments as required in the RFP may result in disqualification. *See* RFP, § II.E.2.

WellCare's 2015 disqualification from the award of an Iowa Medicaid contract and the subsequent termination of its contract in Iowa forecloses any argument that WellCare was unaware that the Settlement Agreement imposed sanctions, and that the CIA required corrective actions, within the scope of Question 10 of the RFP. It is equally inconceivable that WellCare somehow forgot a \$137.5 million settlement, a five-year long CIA, or the FBI raids and criminal actions against former WellCare executives that led up to the Settlement Agreement and CIA.⁷

WellCare's failure to disclose these matters cannot be countenanced, and renders its Proposal substantially incomplete and misleading. WellCare's nondisclosure deprived the Department of the opportunity to evaluate these sanctions and corrective actions in connection with the RFP, and irreparably taints the award to WellCare, such that WellCare should be disqualified and its Proposal rejected.

HARM TO AETNA AND TO THE PUBLIC

The issues raised in this Protest unquestionably have harmed Aetna. Aetna's improper exclusion from the top-four Offerors awarded contracts pursuant to the RFP is the result of: (1) scoring errors to the detriment of Aetna that, if corrected, places it in the top three or four statewide Offerors; (2) scoring errors improperly favoring AmeriHealth that, if corrected drops its total score and thus also ensures that Aetna is in the top three or four statewide Offerors; and (3) the

⁷ *See* April 3, 2012 Department of Justice Press Release <https://www.justice.gov/opa/pr/florida-based-wellcare-health-plans-agrees-pay-1375-million-resolve-false-claims-act>; *see also*, <https://seekingalpha.com/article/51398-wellcare-plunges-63-percent-on-fbi-raid>; http://articles.orlandosentinel.com/2007-10-26/business/wellcare26_1_husky-wellcare-health-plans-investigation.

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award of a contract to WellCare based on a materially incomplete and misleading Proposal which is subject to rejection and disqualification.

Under these circumstances, the harm not just to Aetna, but to the State of North Carolina and its most vulnerable citizens who depend upon Medicaid, is self-evident. If the issues raised in this Protest are fully addressed as requested, the following ratings result:

Offeror Name	Corrected Results
1. United Health Care	727.76474
2. Aetna	723.26219
3. BCBSNC - Healthy Blue	712.22431
4. AmeriHealth Caritas North Carolina	672.47231
WellCare Health Plans	Disqualified

These issues, standing alone, warrant an award of a contract to Aetna as requested herein. However, to the extent that these issues are not addressed, Aetna requests further reconsideration of the awards, and re-evaluation and/or re-procurement, based on concerns regarding the scope of the RFP and the evaluation process. In this regard, Aetna notes that, on February 4, 2019 and February 13, 2019, it served public records requests seeking documents from the Department, including among other things, unredacted documents pertaining to other Offerors' proposals. (See Ex. 19 (public records requests served in connection with the RFP)). Because Aetna's requests have not been fully satisfied as of the date of this Protest, Aetna reserves the right to amend and/or supplement this Protest as may be appropriate once complete records, including unredacted proposals, have been provided and there has been a reasonable period of time for review.

Finally, Aetna has concerns regarding references made by the Evaluation Committee to making "modifications" to the "criteria/rating definitions," to liberties taken by certain Offerors in ignoring page limits (the full extent of which is not clear due to redactions), and to opportunities given to some, but not all Offerors to provide clarifications to their responses. Aetna accordingly requests the opportunity to further address these issues at the Protest Meeting and once the issues relating to outstanding public records requested have been resolved.

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REQUEST FOR RELIEF

For the foregoing reasons, Aetna respectfully requests a Protest Meeting to address the issues outlined herein and for the Department to provide the following relief:

- (1) to re-evaluate the scoring and rankings of the statewide Offerors in accordance with and as required by the RFP;
- (2) to disqualify WellCare of North Carolina for its inexcusable omissions and reject its Proposal; and
- (3) to issue a contract to Aetna as it is one of the top-four statewide Offerors.

Alternatively, Aetna requests such other relief as may be necessary to remedy the issues raised in this Protest, as may be amended and supplemented, including, if necessary, re-evaluation and/or re-procurement.

Finally, given the extremely narrow divide between the top five statewide Offerors, it is imperative that North Carolina's launch of managed care for Medicaid go forward only after the Department has had the opportunity to ensure that the best and most qualified PHPs have been selected. Accordingly, to ensure that the correct result is reached and avoiding undue prejudice, including, but not limited to, market and member confusion, Aetna respectfully requests that the Department stay the award and/or implementation of PHP contracts during the pendency of Aetna's Protest and any further proceedings that may be had regarding this matter, so that the issues to be raised therein can be addressed in an orderly and timely manner. There is no identifiable prejudice to the State or any of the parties awarded a contract since the State appropriately built in enough time to implement the awards once this Protest is fairly and justiciably reviewed.

We genuinely thank you for your consideration and look forward to working with you to resolve the issues raised herein. In the meantime, please do not hesitate to contact me or Kevin Cosgrove at (757) 640-5342 if you have any questions, comments, or to address our request for a Protest Meeting.

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Sincerely,

A handwritten signature in black ink, appearing to read "TB/sr". The signature is fluid and cursive, with the letters "T" and "B" being prominent.

A. Todd Brown, Sr.

Respondent's Memorandum in Opposition to
Aetna Better Health of North Carolina, Inc.'s
Motion and Memorandum for Leave to Amend
its Petition for a Contested Hearing

Exhibit 15

Deposition Exhibit 431



Photo above: Aetna met with Partners Ending Homelessness in Greensboro to sponsor Welcome Home Baskets, which include basic household goods for those transitioning into housing.

Protest Presentation

RFP#: 30-190029-DHB



Aetna Better Health of North Carolina, Inc.



April 4, 2019

Table of Contents

- I. Experience
- II. Scoring discrepancies
- III. AmeriHealth Caritas (“AmeriHealth”) was improperly awarded points for inadequate and incomplete answers to RFP questions
- IV. WellCare of North Carolina, Inc.’s (“WellCare”) proposal is flawed and should be disqualified
- V. Adjusted scoring

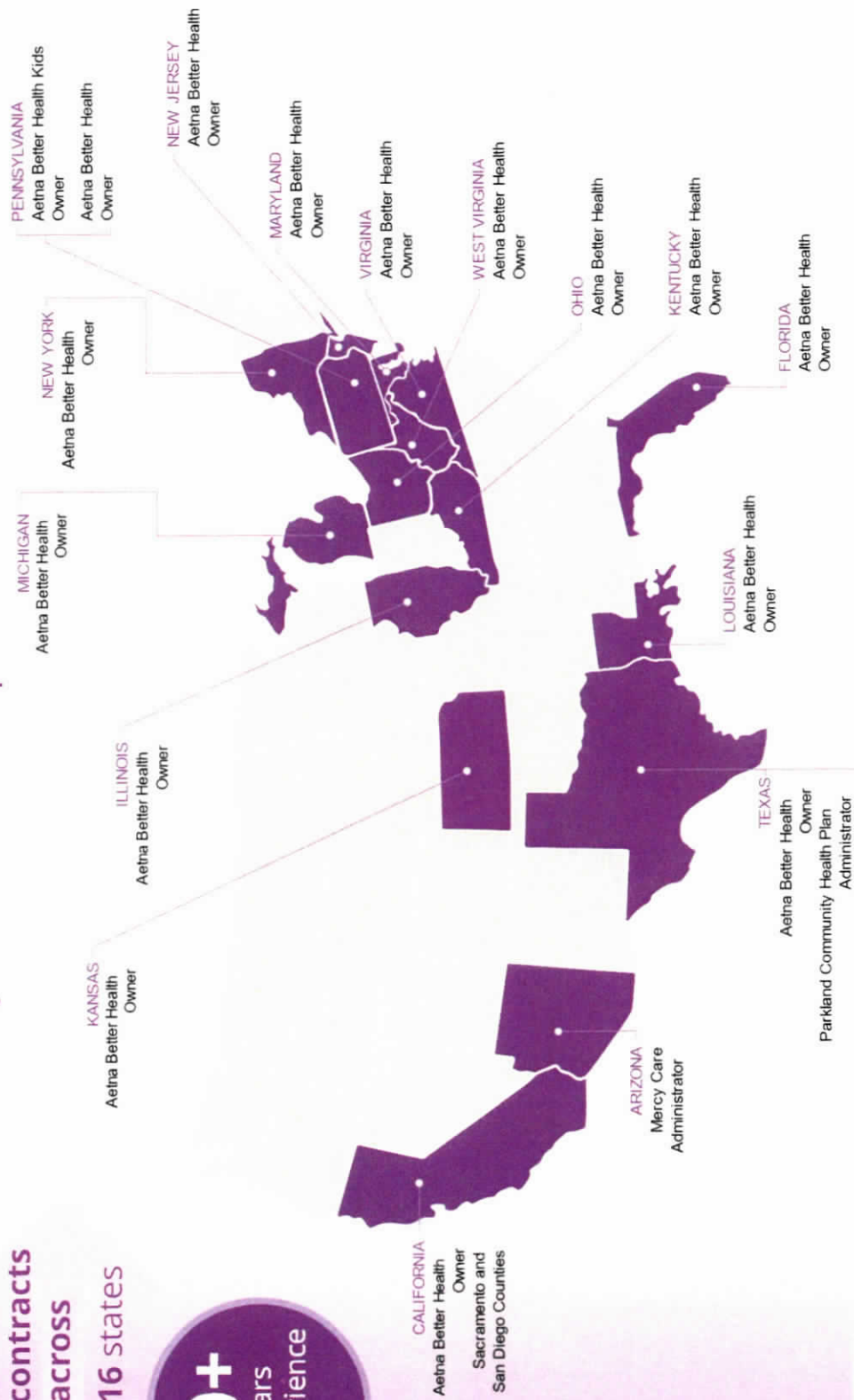
Aetna Medicaid Experience

Aetna scored the **highest** of all bidders in the Offeror Qualifications/Experience Section.

37 contracts
across

16 states

30+
years
experience



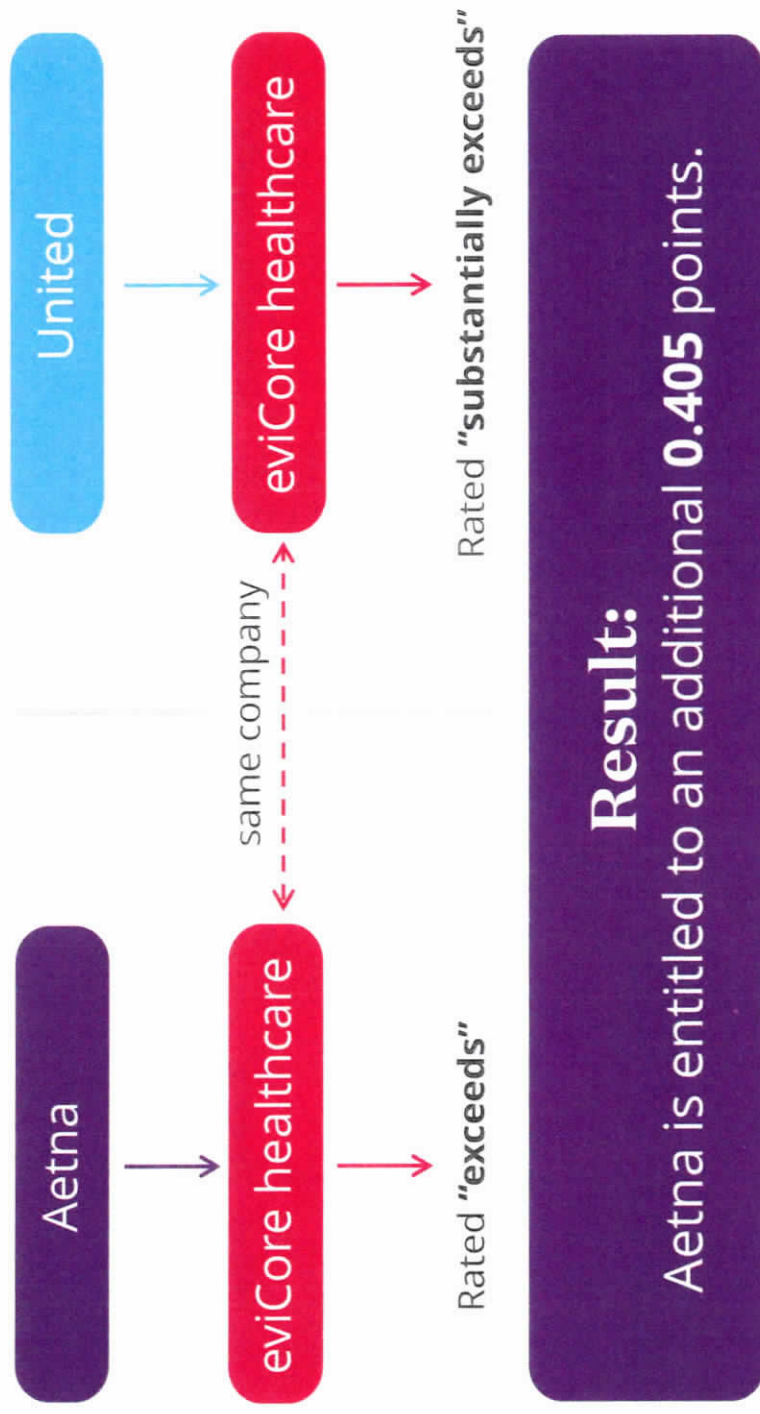
Scoring discrepancies



Q5: Caremark v. CVS



Q5: MSI LLC ("eviCore") v. eviCore



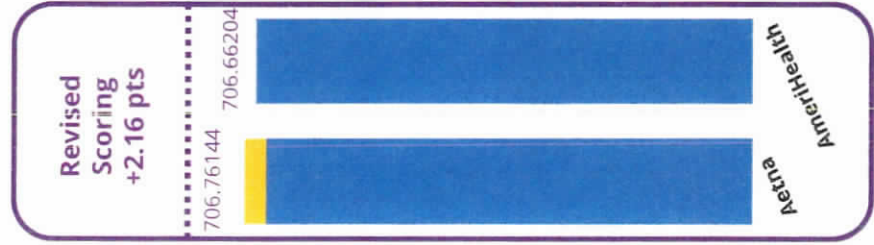
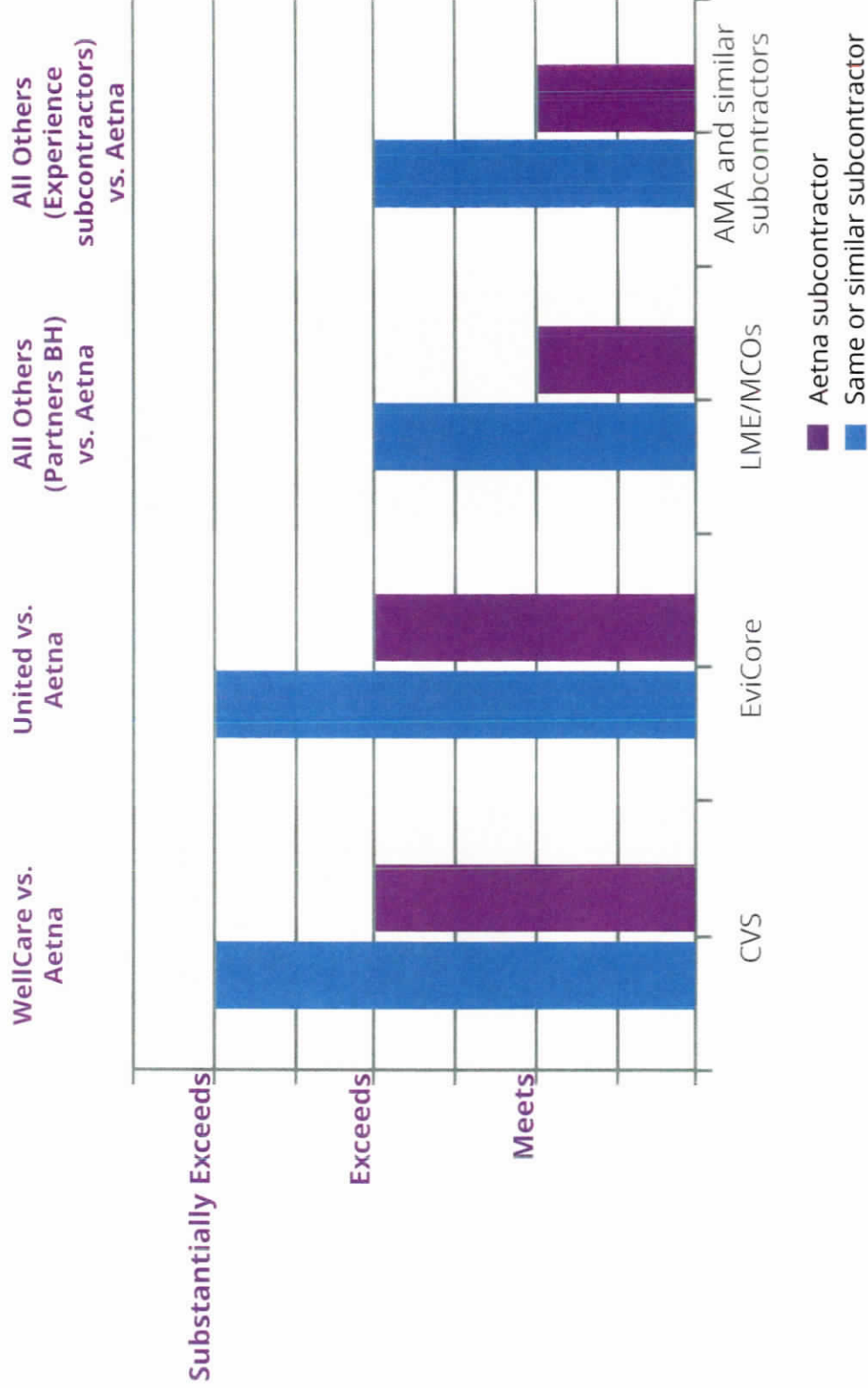
Q5: Partners BH v. all other LME/MCO partners



Q5: Aetna Medicaid Administrators v. BCBS & United subcontractors



Q5: Summary of scoring discrepancies



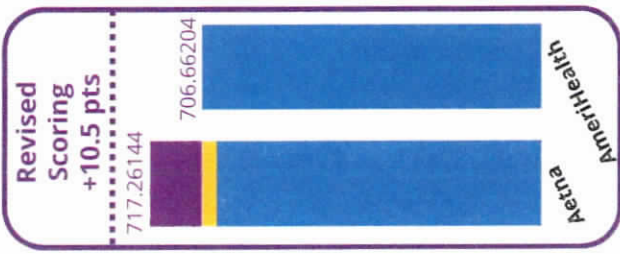
Q46: VBS arrangements

Evaluation Question

46. The Offeror shall confirm its adherence and describe its approach to meeting the Department's expectations and requirements for Value Based Payments stated in Section V.E.2. *Value Based Payments/Alternative Payment Models*, including a description of the PHP's approach to ensuring payments to Providers are increasingly focused on population health, appropriateness of care and other measures related to value. The Offeror shall also include a description of its IT infrastructure and how that system will support moving toward value-based payment, including shared savings and/or risk-sharing across different provider types, care settings and locations. The Offeror shall detail any limitations and/or issues with meeting the Department's expectations or requirements. The response shall include:

- a. A description of value-based payment arrangements the Offeror has used in up to 2 other locations (e.g., another state or region). Include the corresponding LAN frameworks, the location, the volume of payments and patients, and the percent of total premium flowing to providers through shared savings and other incentive arrangements in the response. The Offeror shall include how the PHP made progress over time and used VBP to improve outcomes. Include outcome and cost measures in your response;

"In up to 2 other locations" is a ceiling, not a floor.



Aetna	AmeriHealth	BCBSNC
✓ 2 examples	X 5 examples	X 22 examples
Meets	Exceeds	Exceeds

Aetna is a nationwide leader in value-based reimbursement and has numerous value-based contract arrangements that could have been shared if we didn't follow the State's instructions.



Q48: Community engagement



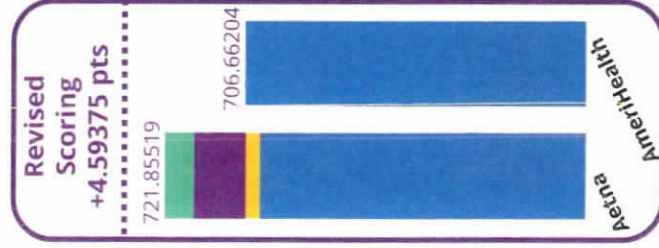
WellCare met with 200
Community Based
Organizations (CBOs)



Aetna met with 1,000
Community Based Organizations (CBOs)

AND

- ✓ Partnered with Community Care of North Carolina, a known entity in all of the regions of the State
- ✓ Engaged in extensive efforts in North Carolina to tackle the opioid crisis
- ✓ Proposed a Community Health Worker Pilot
- ✓ Supported schools with Jobs for America's Graduates (JAG) program
- ✓ Provided monetary donations for hurricane relief and food insecurity
- ✓ Hosted focus groups that informed our additional benefits offerings
- ✓ Proposed co-location of staff in CBOs
- ✓ Proposed maintaining a housing specialist on staff at the plan to help with housing related issues



Q56: Encounters

Evaluator Notes for Question 56

PROVIDE SUPPORTING DOCUMENTATION (not eligible to include a Draft Encounter Implementation Approach)	Does Not Meet	0.00000	Use the 5-rating scale	Response demonstrates a poor understanding of all expectations as it provides a timeline only of activities and does not address the requirements of Section V.K.6.c. Specifically, it lacks the approach to meeting performance, accuracy and timeliness requirements, a technology model, and other required supporting information

Evaluation Question

56. The Offeror shall confirm its adherence and describe its approach to meeting the Department's expectations and requirements outlined in **Section V.H.2 Encounters**. The Offeror shall detail any limitations and/or issues with meeting the Department's expectations or requirements. The response shall include:

- Performance management strategies to ensure complete, accurate and timely encounter data submissions are made to the Department and meet the standards required under the Contract;
- Demonstrated understanding of the importance of accurate, complete and timely Medical and Pharmacy encounter data to the Department for use in the North Carolina Medicaid and NC Health Choice programs. In addition, Offeror shall specifically include steps to support drug rebates and steps to support capturing all applicable diagnosis information on encounters to support risk adjustment;
- Operating model including staffing to support the encounter development and submission process;
- Description of the Offeror's past performance in complying with encounter submission SLAs for other Medicaid customers including the acceptance rates as percentages;
- Leading practices it has adopted to improve data quality in encounter submission, include applicable policies and procedures and the Offeror's use of the Post Adjudicated Claims Data Reporting (PACDR) version of the X12 837 transaction;
- Procedure to work with providers and internal operations in correcting Encounter errors; and
- Describe the challenges and associated mitigation approaches with encounter data submission (including managing denied claim submission, duplicate submissions, sub capitated claims, value-based arrangements, or non-traditional services such as ILOS, value-added services, health-related resources) and specific steps taken to remediate issues, include specific data on outcomes achieved.

PROVIDE SUPPORTING DOCUMENTATION (not part of page count) to include a Draft Encounter Implementation Approach

Revised
Scoring
+1.407 pts

723.26219

706.66204

Aetna
Amerihealth

Question 56 requested the PHP confirm adherence and describe the approach for meeting the requirements and expectation as listed in V.H.2. It did not request the draft encounter implementation approach to include the requirements of V.K.6.c. Although Aetna addressed V.K.6.c elements in its narrative, we were marked as Does Not Meet with notes stating we did not address elements in V.K.6.c



**AmeriHealth Caritas
("AmeriHealth")
was improperly awarded
points for inadequate and
incomplete answers
to RFP questions**



Q50: Emergency member service lines in NC

Section V.G. Table 1: Member and Provider Support Call Center Operations

Service Line Name	Hours of operation	Required to be located in North Carolina	Include on Member ID card
i. Member Service Line	<p>1. Non-emergency Member issues: Monday – Saturday: 7AM – 6PM ET for Member questions and additional hours as required by the Department during times of expected high volume (e.g. managed care launch)</p> <p>2. Emergency Member issues: open twenty-four (24) hours per day / seven (7) days per week</p> <p>3. Open all State holidays</p>	Yes	Yes

AmeriHealth stated its Emergency call center for NC will be located in Philadelphia, PA

Aetna committed to locating our Emergency call center in NC



Q62: AmeriHealth's omission of core vendors

AmeriHealth listed only two vendors as performing core functions in the required field on Q#62 as seen below, but their narrative discussed the significant role of two additional vendors, **Optum** and **Change Healthcare Coding Advisor** (page 488). AmeriHealth **did not** list either of these vendors in the required field in Q#62, Q#5 and Q#9.

62. List all Entities identified in Question #5 of the Offeror's Proposal and Response that are performing core functions or proposed experiences related to this response.

- Cotiviti
- Health Management Systems (HMS)

Retrospective data mining and recovery operations include multiple internal and external layers of review. AmeriHealth Caritas engages external vendors HMS, Cotiviti, and Optum in these operations. Using claims, Member eligibility, provider files, and third-party liability files, HMS and

Change Healthcare Coding Advisory

AmeriHealth Caritas North Carolina will use Change Healthcare Coding Advisor after we have one year of North Carolina claims data. Developed in response to an industry wide need to reduce

Excerpts from Question #62 (pg 488)

AmeriHealth's response to Question #5.

a. Entities performing Core Medicaid Operational Functions for the Offeror (Subcontractors):

<ul style="list-style-type: none"> • Alliance Behavioral Healthcare (Advancing NC Whole Health Coalition) • AmeriHealth Caritas Services • Avesis Third Party Administrators • Cotiviti • Discovery Health Partners • Health Management Systems (HMS) • LogistiCare Solutions • National Imaging Associates (NIA) • Orange Health Solutions d/b/a Citra Health Solutions • PerformRxSM • SourceHOV Healthcare • Trillium Health Resources (Advancing NC Whole Health Coalition) • Vaya Health (Advancing NC Whole Health Coalition) 	15
---	----



**WellCare's proposal
is flawed and should be
disqualified**



Q10: WellCare's failure to disclose sanctions and corrective action information

Evaluation Question	Response
<p>10. The Offeror shall disclose all sanctions imposed against the Offeror as part of a managed care contract in the past seven (7) years in the <i>Attachment O. Offeror's Proposal and Response Table 6: Disclosure of Imposed Sanctions as part of a Managed Care Contract in Past 7 Years</i>. For the purposes of this question, a sanction shall include any monetary penalty, including e.g., civil monetary penalty or liquidated damage. The Offeror's response shall include information for the Offeror as well as all entities identified as performing a Core Medicaid Operations Function in Question #5.</p> <ul style="list-style-type: none"> • If imposed, describe the nature of the sanction, the underlying action leading to the sanction, the market in which the sanction was imposed, and the assessed monetary amount (if applicable). • Describe any corrective actions taken to prevent any future occurrence of the problem leading to the sanction(s). • If the sanction(s) was the subject of an administrative proceeding or litigation, indicate the result of the proceeding/litigation. <p>Offeror must fill out 1 table for each imposed sanction. Completed tables shall not be counted toward the Offeror's total page guidelines.</p>	
<p>Please see the attached tables for each sanction imposed against WellCare of North Carolina and WellCare Health Plans affiliate markets for the past seven (7) years. None of the entities from Question #5 reported information on sanctions imposed as part of a managed care contract in the past seven (7) years.</p>	

Q10: WellCare's sanction and corrective action information timeline

March 23, 2012

Settlement

Agreement imposing \$137.5 million monetary sanction.

December 18, 2015

WellCare's Iowa Medicaid contract award is reversed and its contract terminated for WellCare's failure to disclose:

- \$137.5 million Monetary sanction and
- corresponding Corporate Integrity Agreement (CIA) as a corrective action.

October 19, 2018

Proposals due. WellCare fails to disclose sanctions and corrective actions required by Question 10.

2012

2015

2016

2018

March 2015

WellCare submits final settlement payment to Civil Division.

February 12, 2016

Polk County Court affirms the Final Decision of the Iowa Department of Human Services.

August 9, 2018

RFP #30-190029-DHB released. Question 10 required disclosure of all sanctions imposed during the past seven years as part of a managed care contract and any related corrective actions.



Q10: The Settlement Agreement was within the Look-back Period

March 23, 2012

Settlement
Agreement imposing

December 18, 2015

WellCare's Iowa Medicaid contract
award is reversed and its contract
terminated for WellCare's failure

October 19, 2018

Proposals due.

31. The Effective Date of this Agreement shall be as follows. If no Relator objects to, or otherwise demands a hearing regarding this settlement, the Effective Date shall be the date of signature of the last signatory to the Agreement (Effective Date of this Agreement). For the purposes of this paragraph, the signatories to the Agreement are the United States, WellCare and its counsel, and the Relators to the Civil Actions and their counsel. For the purposes of this

March 2015
WellCare
submits final
settlement
payment to
Civil Division.

February 12, 2016
Polk County Court
affirms the Final
Decision of the Iowa
Department of
Human Services.

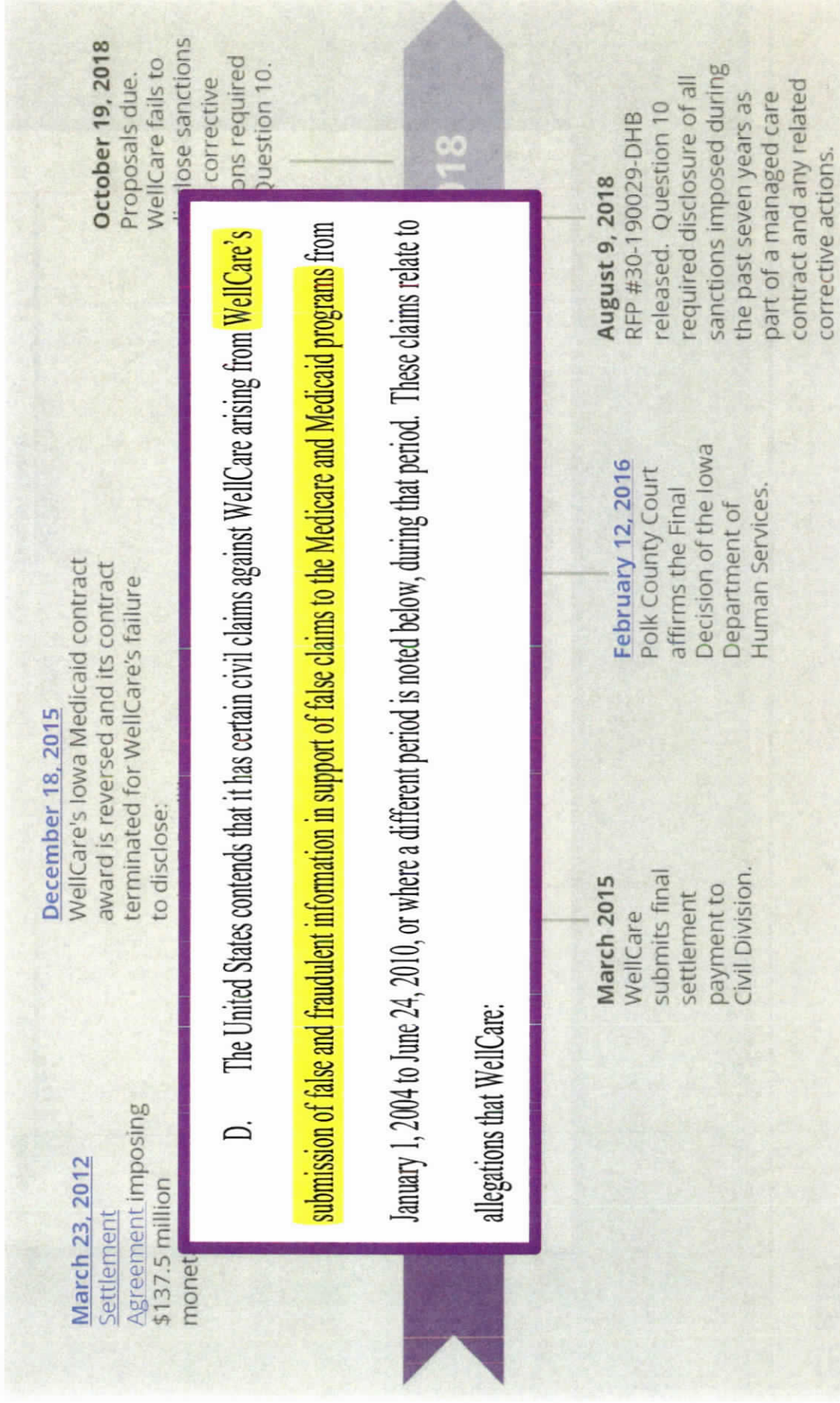
August 9, 2018
RFP #30-190029-DHB
released. Question 10
required disclosure of all
sanctions imposed during
the past seven years as
part of a managed care
contract and any related
corrective actions.



Q10: The Settlement Agreement was within the Look-back Period

<u>March 23, 2012</u> Settlement Agreement imposing \$137.5 million monetary penalty	<u>December 18, 2015</u> WellCare's Iowa Medicaid contract award is reversed and its contract terminated for WellCare's failure to disclose:	<u>October 19, 2018</u> Proposals due. WellCare fails to disclose actions required in 10.
<u>RELATOR SEAN HELLEIN</u>		
<u>3/23/2012</u> Date	BY: <u>/s/ Sean Hellein</u> Sean Hellein Relator	
<u>3/23/2012</u> Date	BY: <u>/s/ Barry A. Cohen</u> Barry A. Cohen Kevin Darken Cohen, Foster & Romine, P.A. Counsel for Relator	
<u>3/23/2012</u> Date	BY: <u>/s/ Daniel Gasti</u> Daniel Gasti Counsel for Relator	

Q10: The Sanctions arose from and were part of WellCare's Managed Care Contracts with various State Medicare and Medicaid Programs



Q10: WellCare's continued ability to perform under managed care contracts was subject to the Settlement Agreement

December 18, 2015
WellCare's Iowa Medicaid contract

March 23, 2012

5. In consideration of the obligations of WellCare in this Agreement and the Corporate Integrity Agreement (CIA), entered into between OIG-HHS and WellCare, conditioned upon WellCare's full payment of the Settlement Amount OIG-HHS agrees to release and refrain from instituting, directing, or maintaining any administrative action seeking exclusion from Medicare, Medicaid, and other Federal health care programs (as defined in 42 U.S.C. § 1320a-7b(f)) against WellCare under 42 U.S.C. § 1320a-7a (Civil Monetary Penalties Law) or 42 U.S.C. § 1320a-7(b)(7) (permissive exclusion for fraud, kickbacks, and other prohibited activities) for the Covered Conduct, except as reserved in Paragraph 6 (concerning excluded claims), below, and as reserved in this Paragraph. OIG-HHS expressly reserves all rights to comply with any statutory

March 2015
WellCare submits final settlement payment to Civil Division.

February 12, 2016
Polk County Court affirms the Final Decision of the Iowa Department of Human Services.

August 9, 2018
RFP #30-190029-DHB released. Question 10 required disclosure of all sanctions imposed during the past seven years as part of a managed care contract and any related corrective actions.

Q10: Iowa – the \$137.5 million payment imposed by the Settlement Agreement was a penalty to resolve “false claims under contracts relating to Medicaid managed care services”

March 23, 2012
Settlement
Agreement imposing
\$137.5 million
monetary sanction.

Iowa Department of Inspections and Appeals
Division of Administrative Hearings
Wallace State Office Building – Third Floor
Des Moines, Iowa 50319

Iowa Total Care, Inc.,)	Appeal No. 16001573
Meridian Health Plan of Iowa, Inc., and)	Appeal No. 16001590
Aetna Better Health of Iowa, Inc.,)	Appeal No. 16001623
Appellants,)	
v.)	
Iowa Department of Human Services,)	

As an initial matter, I find the fact that the false claims act claims were resolved through settlement virtually irrelevant. The third bullet point of section 3.2.5.4 (the first quoted above), clearly required the disclosure of all types of monetary payments made or withheld under any existing or past contract regardless of the context in which the payments were made. The inquiry in no way limited the context in which payments were made. That WellCare made the \$137.5 million payment to resolve false claim litigation, to avoid potential suspension from the Medicaid program, rather than in response to an audit claim is beside the point. WellCare paid a penalty within the last five years, to resolve liability related to false claims under contracts relating to Medicaid managed care services. WellCare should have disclosed the payment in its initial response to section 3.2.5.4 of the RFP.

Q10: Iowa - the \$137.5 million payment imposed by the Settlement Agreement was a Sanction

March 23, 2012
Settlement
 Agreement imposing
 \$137.5 million
 monetary sanction.

2012

Iowa Department of Inspections and Appeals
 Division of Administrative Hearings
 Wallace State Office Building – Third Floor
 Des Moines, Iowa 50319

Iowa Total Care, Inc.,)	Appeal No. 16001573
Meridian Health Plan of Iowa, Inc., and)	Appeal No. 16001590
Aetna Better Health of Iowa, Inc.,)	Appeal No. 16001623
Appellants,)	
)	
v.)	
)	
Iowa Department of Human Services,)	
)	
Respondent,)	

I recognize that the \$137.5 million settlement payment may not have fallen within the ambit of this section. Although it was a monetary sanction paid within the past five years, arguably the sanction was not imposed by a regulatory agency. The same is not true of the Corporate Integrity Agreement. Through this agreement, entered within the past five years, HHS required WellCare to take corrective actions to prevent a repetition of past misconduct. HHS is a regulatory agency. WellCare's obligations under the agreement run for five years and remain in effect. I conclude RFP section 3.2.7.4.2 required disclosure of the existence of the CIA.

Q10: Iowa – the CIA required WellCare to take Corrective Actions to address the problems that led to the Sanction

March 23, 2012
Settlement
Agreement imposing
\$137.5 million
monetary sanction.

Iowa Department of Inspections and Appeals
Division of Administrative Hearings
Wallace State Office Building – Third Floor
Des Moines, Iowa 50319

Iowa Total Care, Inc.,) Appeal No. 16001573
Meridian Health Plan of Iowa, Inc., and) Appeal No. 16001590
Aetna Better Health of Iowa, Inc.,) Appeal No. 16001623

Appellants,

v.

I recognize that the \$137.5 million settlement payment may not have fallen within the ambit of this section. Although it was a monetary sanction paid within the past five years, arguably the sanction was not imposed by a regulatory agency. The same is not true of the Corporate Integrity Agreement. Through this agreement, entered within the past five years, HHS required WellCare to take corrective actions to prevent a repetition of past misconduct. HHS is a regulatory agency. WellCare's obligations under the agreement run for five years and remain in effect. I conclude RFP section 3.2.7.4.2 required disclosure of the existence of the CIA.

Q10: Iowa – Based on Findings by the ALJ, the Department Reverses Award and Terminates Contract

IOWA DEPARTMENT OF HUMAN SERVICES HOOVER STATE OFFICE BUILDING – FIFTH FLOOR DES MOINES, IOWA 50319

Iowa Total Care, Inc.
Meridian Health Plan of Iowa, Inc., and
Aetna Better Health of Iowa, Inc.,

Appellants,

v.

Iowa Department of Human Services,

Respondent,

Amerigroup Iowa, Inc., AmeriHealth Caritas,
Inc., United Healthcare Plan of the River
Valley, Inc., and WellCare of Iowa, Inc.,

Intervenors.

26

Appeal No. 16001573
Appeal No. 16001590
Appeal No. 16001623

FINAL DECISION

Aetna Better Health (Aetna), WellCare of Iowa, Inc. (WellCare), Meridian Health Plan of Iowa, Inc. (Meridian), and the Iowa Department of Human Services (DHS) filed timely Requests for Review of the Proposed Decision issued on November 25, 2015. Review was granted on December 8, 2015.

For the reasons set forth below, the Notice of Intent to Award is AFFIRMED as to Amerigroup Iowa, Inc., AmeriHealth Caritas, Inc., and UnitedHealthcare Plan of the River Valley. The Notice of Intent to Award is REVERSED as to WellCare of Iowa, Inc. and its contract with DHS is terminated.

Marc
Settle
Agree
\$137.
mone

Q10: Iowa – even after the “lengthy” clarifying response, WellCare’s failure to provide full disclosure deprived Department of opportunity to exercise discretion

March 23, 2016
Settlement
Agreement
\$137.5 million
monetary sum

**IOWA DEPARTMENT OF HUMAN SERVICES
HOOVER STATE OFFICE BUILDING – FIFTH FLOOR
DES MOINES, IOWA 50319**

Iowa Total Care, Inc.
Meridian Health Plan of Iowa, Inc., and
Aetna Better Health of Iowa, Inc.,

Appellants,

Appeal No. 16001573
Appeal No. 16001590
Appeal No. 16001623

I make the following additional Conclusions of Law: “In this case, the full record now before me shows that WellCare failed to disclose highly relevant information both in its initial response to the RFP and in its “clarifying” answer. In doing so, WellCare not only violated the terms of the RFP but also deprived the agency decision-makers – both the evaluation committee and Director Palmer – of the opportunity to fully exercise their discretion in determining which Bid Proposals would provide ‘the greatest benefit to the Agency.’ Accordingly, with the benefit of that record, I now conclude that WellCare’s Bid Proposal is disqualified and the subsequent contract between WellCare and DHS is terminated.”

Valley. The Notice of Intent to Award is REVERSED as to WellCare of Iowa, Inc. and its contract with DHS is terminated.

Q10: Iowa – the Iowa Court agreed that the lack of full disclosure precluded the exercise of discretion

March 23, 2012
Settlement
Agreement imposing
\$137.5 million
monetary sanction.

IN THE IOWA DISTRICT COURT FOR POLK COUNTY

WELLCARE OF IOWA, INC., and
MERIDIAN HEALTH PLAN OF IOWA,
INC.,

Petitioners,

v.

IOWA DEPARTMENT OF HUMAN

Case No. CVCV051022

WellCare also disputes the conclusion that it failed to disclose information required by the RFP.

WellCare argues that not only did it disclose the information, but it was not actually required to make the disclosures. WellCare avers that the committee was fully aware of the information in its disclosures and could not have deprived the committee and Director Palmer of the ability to exercise discretion.

The true extent of WellCare's settlements and the actual details of the CIA were not disclosed to DHS until the contested hearing in October 2015. If DHS was unaware of the extent of WellCare's legal problems until that time, it could not have been fully informed and able to exercise discretion. Only after that information came out at the contested hearing was DHS, through the Final Decision, able to exercise discretion and find that WellCare failed to disclose required information. There is substantial evidence to conclude that WellCare violated the RFP by failing to disclose information and deprived the committee and Director Palmer of discretion.

Q10: Iowa - the Iowa Court affirmed the termination of WellCare's managed care contract

March 2
Settlement
Agreement
\$137.5 million

E-FILED 2016 FEB 12 11:43 AM POLK - CLERK OF DISTRICT COURT

IN THE IOWA DISTRICT COURT FOR POLK COUNTY

**WELLCARE OF IOWA, INC., and
MERIDIAN HEALTH PLAN OF IOWA,
INC.,**

Petitioners,

v.

**IOWA DEPARTMENT OF HUMAN
SERVICES,**

Defendant.

AMERIGROUP IOWA, INC.,

Case No. CVCV051022

**RULING ON PETITION
FOR JUDICIAL REVIEW**

The Final Decision of December 18, 2015 is affirmed. The petitions are dismissed with costs assessed to Petitioners.

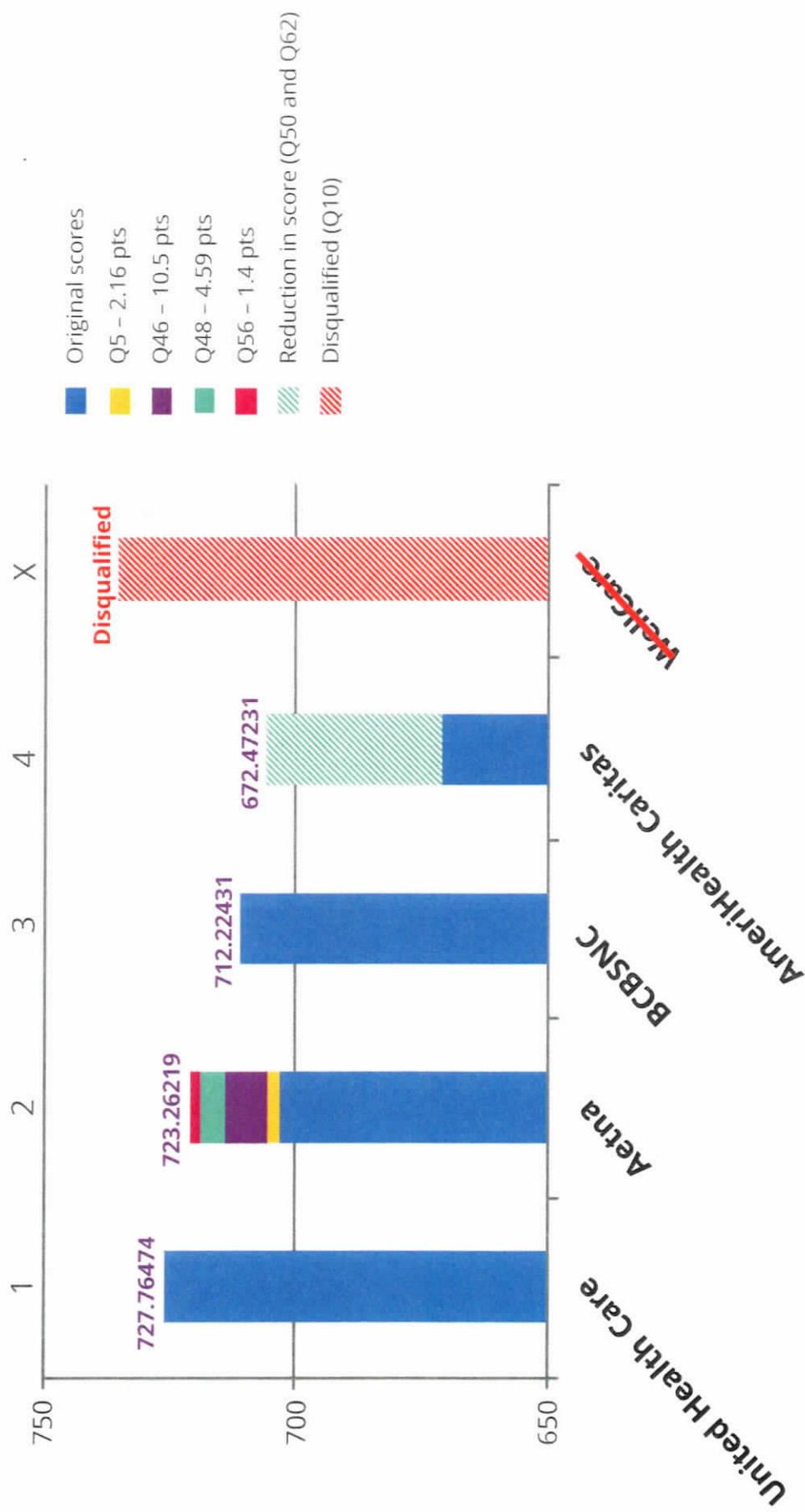
contract and any related
corrective actions.



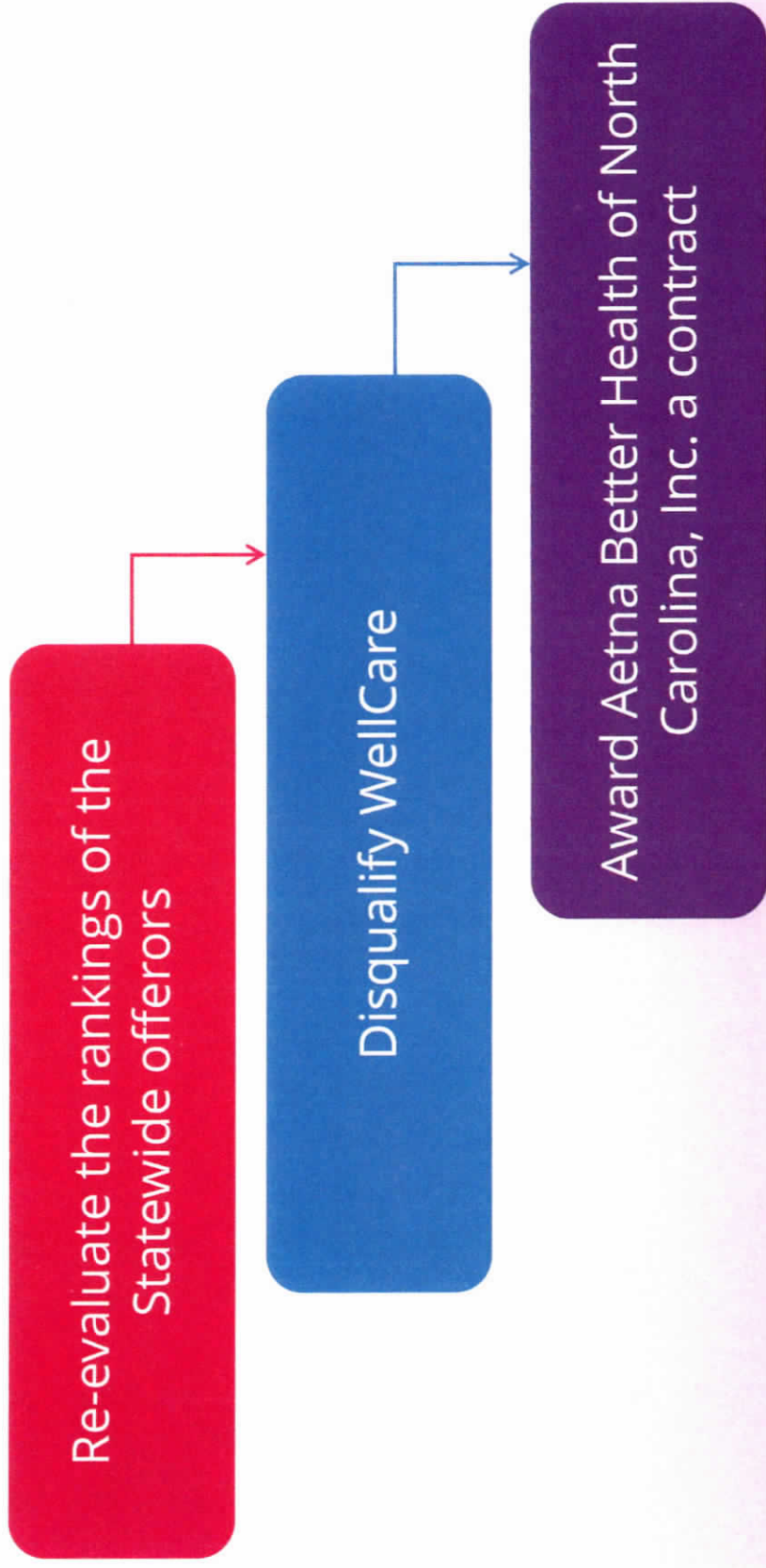
Adjusted scoring



Adjusted scoring pending Aetna's findings



Our Ask of NC DHHS



Aetna Better Health of North Carolina, Inc. is ready to implement today

Respondent's Memorandum in Opposition to
Aetna Better Health of North Carolina, Inc.'s
Motion and Memorandum for Leave to Amend
its Petition for a Contested Hearing

Exhibit 16

Deposition Exhibit 429

Section II. Table 3: Proposal Scoring, Criteria and Overall Weights		
Proposal Evaluation Criteria	Sub Weight	Weights
3. USE CASES		5%
4. CLIENT REFERENCES		5%
5. BONUS POINTS: Marketplace Participation		2.5%

5. Contract Award

Upon conducting a comprehensive, fair, and impartial evaluation of the proposals received in response to this RFP, the Department reserves the right to award multiple contracts resulting from this RFP. Upon award, the Department will sign the "Acceptance of Proposal" found at the bottom of the Execution of Proposal Section or require the signing of an Execution of Contract, thus resulting in the formation of the Contract(s). Within two (2) business days after notification of award, the Offeror must register in NCE-Procurement @ Your Service. See <http://vendor.ncgov.com>.

6. Protest Procedures: If an Offeror wishes to protest a Contract resulting from this solicitation that is awarded by the Department, the Offeror shall submit a written request addressed to contact identified in *Section II.E.6 Proposal Submission and Number of Copies*. The protest request must be received in the proper office within thirty (30) calendar days from the Contract Award. Protest letters shall contain specific grounds and reasons for the protest, how the protesting party was harmed by the award made and any documentation providing support for the protesting party's claims. **Note:** Contract Award notices are sent only to the Offeror awarded the Contract, and not to every person or firm responding to a solicitation. Proposal status and Award notices are posted on the Internet at <https://www.ips.state.nc.us/ips/>. All protests will be handled following the process defined in the North Carolina Administrative Code, 01 NCAC 05B.1519, but will be administered by Department of Health and Humans Services personnel.

7. Administrators for the Contract

The Offeror must complete *Attachment O.7. Contractor's Contract Administrators*.



STATE OF NORTH CAROLINA

COUNTY OF WAKE

IN THE OFFICE OF
ADMINISTRATIVE HEARINGS

Optima Family Care of North Carolina, Inc.,
Petitioner,

v.

North Carolina Department of Health and
Human Services, Mandy Cohen, M.D., MPH,
in her official capacity as Secretary of the
Department, and Dave Richard in his official
capacity as Deputy Secretary of the
Department for NC Medicaid,

Respondent,

and

WellCare of North Carolina, Inc., Blue Cross
And Blue Shield of North Carolina,
AmeriHealth Caritas of North Carolina, Inc.,
UnitedHealthCare of North Carolina, Inc.,
Carolina Complete Health, Inc., and North
Carolina Provider owned Plans, Inc. d/b/a My
Health by Health Providers,

Respondent-Intervenors.

19 DHR 01959

North Carolina Provider Owned Plans, Inc.
d/b/a My Health By Health Providers,
Petitioner,

v.

North Carolina Department of Health and
Human Services,

Respondent,

and

UnitedHealthCare of North Carolina, Inc.,
Blue Cross And Blue Shield of North
Carolina, WellCare of North Carolina, Inc.,
AmeriHealth Caritas of North Carolina, Inc.,
Carolina Complete Health, Inc., and Optima
Family Care of North Carolina, Inc.,

Respondent-Intervenors

19 DHR 02032

Aetna Better Health of North Carolina, Inc.,
d/b/a Aetna Better Health of North Carolina,
Petitioner,
v.
State Of North Carolina Department of Health
and Human Services – Division of Health
Benefits,
Respondent,
and
WellCare of North Carolina, Inc., Blue Cross
And Blue Shield of North Carolina,
AmeriHealth Caritas of North Carolina, Inc.,
UnitedHealthCare of North Carolina, Inc.,
Carolina Complete Health, Inc., and North
Carolina Provider Owned Plans, Inc. d/b/a My
Health By Health Providers,
Respondent-Intervenors.

19 DHR 02194

Carolina Complete Health, Inc.,
Petitioner,
v.
North Carolina Department of Health and
Human Services,
Respondent,
and
AmeriHealth Caritas of North Carolina, Inc.,
and North Carolina Provider Owned Plans,
Inc. d/b/a My Health By Health Providers,
Respondent-Intervenors.

19 DHR 03352

CERTIFICATE OF SERVICE

The undersigned does hereby certify that a true and correct copy of the foregoing document was uploaded electronically with the Office of Administrative Hearings, causing electronic services, as defined in 26 NCAC 03.0501(4), to be made upon the following:

- Respondent's Memorandum in Opposition to Aetna Better Health of North Carolina, Inc.'s Motion and Memorandum for Leave to Amend its Petition for a Contested Case Hearing

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This 4th day of October, 2019

s/ Elizabeth H. Black
Elizabeth H. Black

NORTH CAROLINA

IN THE OFFICE OF
ADMINISTRATIVE HEARINGS

WAKE COUNTY

OPTIMA FAMILY CARE OF NORTH
CAROLINA, INC.,

Petitioner,

vs.

NORTH CAROLINA DEPARTMENT OF
HEALTH AND HUMAN SERVICES,
MANDY COHEN, MD, MPH, in her official
capacity as Secretary of the Department, and
DAVE RICHARD in his official capacity as
Deputy Secretary of the Department for NC
Medicaid,

Respondents,

and

WELLCARE OF NORTH CAROLINA, INC.,
BLUE CROSS AND BLUE SHIELD OF
NORTH CAROLINA; AMERIHEALTH
CARITAS OF NORTH CAROLINA, INC.,
UNITEDHEALTHCARE OF NORTH
CAROLINA, INC.; CAROLINA COMPLETE
HEALTH, INC.,

Respondent-Intervenors,

and

NORTH CAROLINA PROVIDER OWNED
PLANS, INC. d/b/a MY HEALTH BY HEALTH
PROVIDERS,

Intervenor.

19 DHR 01959

NORTH CAROLINA PROVIDER OWNED
PLANS, INC. d/b/a MY HEALTH BY MY
HEALTH PROVIDERS,

Petitioner,

19 DHR 02032

v.)
)
 NORTH CAROLINA DEPARTMENT OF)
 HEALTH AND HUMAN SERVICES,)
)
 Respondents,)
)
 and)
)
 UNITEDHEALTHCARE OF NORTH)
 CAROLINA, INC., BLUE CROSS AND BLUE)
 SHIELD OF NORTH CAROLINA,)
 WELLCARE OF NORTH CAROLINA, INC.,)
 AMERIHEALTH CARITAS OF NORTH)
 CAROLINA, INC., CAROLINA COMPLETE)
 HEALTH, INC.,)
)
 Respondent-Intervenors,)
)
 and)
)
 OPTIMA FAMILY CARE OF NORTH)
 CAROLINA, INC.,)
)
 Intervenor.)
)
 AETNA BETTER HEALTH OF NORTH)
 CAROLINA, INC. d/b/a AETNA BETTER)
 HEALTH OF NORTH CAROLINA,)
)
 Petitioner,)
)
 v.)
)
 STATE OF NORTH CAROLINA)
 DEPARTMENT OF HEALTH AND HUMAN)
 SERVICES,)
)
 Respondent,)
)
 and)
)
 WELLCARE OF NORTH CAROLINA, INC.,)
 BLUE CROSS AND BLUE SHIELD OF)
 NORTH CAROLINA, AMERIHEALTH)
 CARITAS OF NORTH CAROLINA, INC.,)
)

19 DHR 02194

UNITEDHEALTHCARE OF NORTH)
CAROLINA, INC., CAROLINA COMPLETE)
HEALTH, INC.,)
)
Respondent-Intervenors,)
)
and)
)
NORTH CAROLINA PROVIDER OWNED)
PLANS, INC. d/b/a MY HEALTH BY HEALTH)
PROVIDERS,)
)
Intervenor.)

CAROLINA COMPLETE HEALTH, INC.,)
)
Petitioner,)
)
v.)
)
NORTH CAROLINA DEPARTMENT OF)
HEALTH AND HUMAN SERVICES,)
)
Respondent,)
)
and)
)
AMERIHEALTH CARITAS OF NORTH)
CAROLINA, INC.,)
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Respondent-Intervenor,)
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and)
)
NORTH CAROLINA PROVIDER OWNED)
PLANS, INC. d/b/a MY HEALTH BY HEALTH)
PROVIDERS,)
)
Intervenor.)

19 DHR 03352

**OPTIMA FAMILY CARE OF NORTH CAROLINA, INC.'S RESPONSE IN SUPPORT
OF AETNA BETTER HEALTH OF NORTH CAROLINA, INC.'S MOTION AND
MEMORANDUM FOR LEAVE TO AMEND ITS PETITION FOR A CONTESTED
CASE HEARING**

Pursuant to Rule 15 of the North Carolina Rules of Civil Procedure and 26 N.C.A.C. 3.0115, Optima Family Care of North Carolina, Inc. (“Optima”), by and through its undersigned attorneys, responds to Aetna Better Health of North Carolina, Inc.’s Motion and Memorandum for Leave to Amend its Petition for a Contested Case Hearing filed with this Court on September 19, 2019. Although it is not procedurally necessary for Aetna Better Health of North Carolina, Inc. (“Aetna”) to amend its petition for contested case hearing, Optima agrees that Aetna’s motion accurately describes the evidence obtained in discovery, which was not apparent to Petitioners when their petitions were initially filed. Therefore, Optima supports Aetna’s Motion to Amend.

Applicable Procedural Rules

The North Carolina Rules of Civil Procedure apply in the Office of Administrative Hearings (“OAH”) unless another statute or an OAH rule provides otherwise. 26 NCAC 03.0101(a). Unlike a civil matter, a contested case is commenced by the filing of a petition for contested case hearing under N.C. Gen. Stat. § 150B-23, which requires a petitioner to “state facts tending to establish that the agency named as the respondent has deprived the petitioner of property, has ordered the petitioner to pay a fine or civil penalty, or has otherwise substantially prejudiced the petitioner's rights and that the agency:

- (1) Exceeded its authority or jurisdiction;
- (2) Acted erroneously;
- (3) Failed to use proper procedure;
- (4) Acted arbitrarily or capriciously; or
- (5) Failed to act as required by law or rule.”

The Office of Administrative Hearings requires only a minimal statement of the agency action at issue and the agency error alleged by the petitioner. Indeed, filling out a one-page form provided on the OAH web site is sufficient to commence a contested case. *See*

<https://www.oah.nc.gov/documents/form-h-06-general-petition-form>. Unlike a civil action, no answer is required in a contested case.

The statutes and rules governing contested cases do not specifically address amendments to a petition for contested case hearing. N.C. Gen. Stat. Chapter 150B, Article 3, 26 NCAC, Chapter 3. Therefore, Rule 15 of the Rules of Civil Procedure governs Aetna's motion.

Argument

Aetna's initial Petition for Contested Case hearing met all the requirements of N.C. Gen. Stat. § 150B-23 by stating multiple ways in which the Agency exceeded its authority and/or jurisdiction, acted erroneously, failed to use proper procedure, acted arbitrarily or capriciously, and/or failed to act as required by law (collectively "agency error"), and by describing the substantial prejudice to its rights as a result. Aetna now seeks leave to amend to allege additional forms of agency error that were revealed during discovery. Optima agrees with Aetna's description of the evidence learned in discovery and its importance to the contested case, and Optima further agrees that the issues raised therein were not apparent until revealed in discovery.

Because Aetna's initial petition met the minimal pleading requirements of the Administrative Procedure Act, it is not necessary for Aetna to amend its petition. However, no statute or rule applicable to these contested cases would prevent Aetna from amending its petition if it chooses, and Rule 15 authorizes the amendment. Moreover, Rule 15(a) provides that leave shall be freely given to amend pleadings when justice so requires, and Rule 15(b) allows for pleadings to be amended to conform to the evidence. In particular, Rule 15(b) provides, in part, as follows:

If evidence is objected to at the trial on the ground that it is not within the issues raised by the pleadings, the court may allow the pleadings to be amended and shall do so freely when the presentation of the merits of the action will be served thereby

and the objecting party fails to satisfy the court that the admission of such evidence would prejudice him in maintaining his action or defense upon the merits.

"The purpose of an amendment to conform to proof is to bring the pleadings in line with the actual issues upon which the case was tried[.]" *Graphics, Inc. v. Hamby*, 48 N.C. App. 82, 85, 268 S.E.2d 567, 569 (1980) (citation omitted). A trial court's ruling on a motion to amend the pleadings is one that lies within the sole discretion of the trial court, and the trial court's ruling will not be disturbed absent a showing of an abuse of discretion. *Mabrey v. Smith*, 144 N.C. App. 119, 121, 548 S.E.2d 183, 185-86, *disc. review denied*, 354 N.C. 219, 554 S.E.2d 340 (2001) (citations omitted). "The party objecting to the amendment has the burden of establishing it will be materially prejudiced by the amendment." *North River Ins. Co. v. Young*, 117 N.C. App. 663, 671, 453 S.E.2d 205, 210 (1995) (citing *Mauney v. Morris*, 316 N.C. 67, 72, 340 S.E.2d 397, 400 (1986)).

In this case, there would be no prejudice from such an amendment to Respondents and Respondent-Intervenors. The requested amendment flows directly from information discovered from Respondents' own witnesses during the discovery process. All parties were represented by counsel at all depositions. All parties had equal opportunity to ask questions of the witnesses and follow up on the issues raised. Moreover, Aetna's motion was timely because it was filed months before trial and indeed before the close of discovery, giving all parties ample opportunity to prepare for and address the issues at trial.

Conclusion

Aetna's motion accurately describes the evidence learned in discovery, which was not initially apparent when the petition was filed, and the issues raised thereby. Although there is no procedural requirement that Aetna amend its petition at this time, Rule 15 allows amendments when justice requires, and specifically allows for amendments to conform to the evidence. Therefore, Optima supports Aetna's motion to amend and asks that it be allowed.

This the 4th day of October, 2019.

/s/ Marcus C. Hewitt

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CERTIFICATE OF SERVICE

The undersigned does hereby certify that a true and correct copy of the foregoing document was uploaded electronically with the Office of Administrative Hearings, causing electronic service, as defined in 26 N.C.A.C.03.0501(4), to be made upon the following:

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*Counsel for North Carolina Provider Owned
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This the 4th day of October, 2019.

/s/ Marcus C. Hewitt
Marcus C. Hewitt
Attorney for Petitioner

STATE OF NORTH CAROLINA
COUNTY OF WAKE

IN THE OFFICE OF
ADMINISTRATIVE HEARINGS

OPTIMA FAMILY CARE OF NORTH
CAROLINA, INC.

Petitioner,

v.

NORTH CAROLINA DEPARTMENT OF
HEALTH AND HUMAN SERVICES,
MANDY COHEN, M.D., MPH, IN HER
OFFICIAL CAPACITY AS SECRETARY
OF THE DEPARTMENT AND DAVE
RICHARD IN HIS OFFICIAL CAPACITY
AS DEPUTY SECRETARY OF THE
DEPARTMENT FOR NC MEDICAID,

19 DHR 01959

Respondents,

and

WELLCARE OF NORTH CAROLINA,
INC., BLUE CROSS AND BLUE SHIELD
OF NORTH CAROLINA, AMERIHEALTH
CARITAS OF NORTH CAROLINA, INC.,
UNITEDHEALTHCARE OF NORTH
CAROLINA, INC., CAROLINA
COMPLETE HEALTH, INC.,

Respondent-Intervenors.

NORTH CAROLINA PROVIDER OWNED
PLANS, INC. D/B/A MY HEALTH BY
HEALTH PROVIDERS,

Petitioner,

v.

19 DHR 02032

NORTH CAROLINA DEPARTMENT OF
HEALTH AND HUMAN SERVICES,

Respondent,

and

<p>UNITEDHEALTHCARE OF NORTH CAROLINA, INC., BLUE CROSS AND BLUE SHIELD OF NORTH CAROLINA, WELLCARE OF NORTH CAROLINA, INC., AMERIHEALTH CARITAS OF NORTH CAROLINA, INC., CAROLINA COMPLETE HEALTH, INC.</p> <p>Respondent-Intervenors.</p>	
<p>AETNA BETTER HEALTH OF NORTH CAROLINA, INC. D/B/A AETNA BETTER HEALTH OF NORTH CAROLINA,</p> <p>Petitioner,</p> <p>v.</p> <p>STATE OF NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES, RESPONDENT,</p> <p>and</p> <p>WELLCARE OF NORTH CAROLINA, INC., BLUE CROSS AND BLUE SHIELD OF NORTH CAROLINA, AMERIHEALTH CARITAS OF NORTH CAROLINA, INC., UNITEDHEALTHCARE OF NORTH CAROLINA, INC., CAROLINA COMPLETE HEALTH, INC.,</p> <p>Respondent-Intervenors.</p>	<p>19 DHR 02194</p>
<p>CAROLINA COMPLETE HEALTH, INC.,</p> <p>Petitioner,</p> <p>v.</p> <p>NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES,</p> <p>Respondent.</p>	<p>19 DHR 03352</p>

**UNITEDHEALTHCARE OF NORTH CAROLINA, INC.’S MEMORANDUM IN
OPPOSITION TO AETNA BETTER HEALTH OF NORTH CAROLINA INC.’S
MOTION FOR LEAVE TO AMEND ITS PETITION FOR A CONTESTED CASE
HEARING**

UnitedHealthcare of North Carolina, Inc. (“UHC”), by and through its undersigned counsel, hereby submits its Memorandum in Opposition (“Opposition”) to Aetna Better Health of North Carolina Inc.’s (“Aetna”) Motion for Leave to Amend Its Petition for a Contested Case Hearing (“Motion for Leave”).

INTRODUCTION

By its Motion for Leave, Aetna seeks to amend its Petition to include additional facts primarily related to Blue Cross and Blue Shield of North Carolina (“BCBS”) that Aetna claims to have learned for the first time during discovery in this contested case. Aetna also adds a claim related to UHC’s earning of bonus points that it admits would have no effect on the outcome of the competition. At least with respect to the additional facts related to UHC and its receipt of bonus points in this procurement, leave to amend is not warranted under the circumstances here.

Even if the bonus points issue was material to the outcome of the procurement, Aetna knew, or at the very least should have known, about the “new” facts related to UHC long ago. Indeed, Aetna was aware of the facts prior to initiating this contested case, and even prior to submitting its original protest. Nonetheless, Aetna did not raise them in its protest or in its initial Petition. Therefore, Aetna failed to exhaust its administrative remedies, and it waived any right to assert this additional protest ground in this case. Moreover, these additional facts offer nothing by way of support for Aetna’s claims. They do not provide any grounds for disrupting the awarded contracts, or for re-procuring this RFP, and would in fact subject Aetna’s proposed Amended Petition to a motion to dismiss. Accordingly, leave to amend would be futile, it would cause undue

delay, and achieve nothing other than to prejudice the other parties in this case. For these reasons, as explained in detail below, Aetna's Motion for Leave should be denied.

FACTUAL BACKGROUND

On August 9, 2018, the North Carolina Department of Health and Human Services, Division of Health Benefits ("DHHS") released a Request for Proposal #: 30-190029-DHB (the "RFP") seeking proposals for contracts to administer North Carolina's Medicaid managed care program as prepaid health plans ("PHPs") pursuant to N.C. Session Law 2015-245, as amended. Eight entities (the "Offerors"), including UHC and Aetna, submitted proposals in response to the RFP, proposing to participate in statewide contracts and/or regional contracts. In the RFP, among many other questions, DHHS offered offerors bonus points for making a commitment to participate in North Carolina's federally facilitated marketplace by the 2021 plan year, and identifying a geographic footprint for that participation. (*See* Opposition Exhibit ("Exh.") 1, RFP, at Attachment O, at p. 15.¹)

On February 4, 2019, DHHS posted a Managed Care Prepaid Health Plans Contract Awards Fact Sheet (the "Award"), announcing the award of PHP contracts to five Offerors (the "Contracts" or individually, the "Contract"). More specifically, DHHS awarded statewide Contracts to four commercial providers, namely UHC, WellCare of North Carolina, Inc. ("WellCare"), Blue Cross and Blue Shield of North Carolina ("BCBS"), and AmeriHealth Caritas North Carolina, Inc. ("ACNC"), and two regional contracts (for Regions 3 and 5) to a provider-led entity ("PLE"), Carolina Complete Health, Inc. ("CCH"). Thereafter, on or about February 7, 2019, DHHS provided certain documents to the offerors related to the RFP, including redacted

¹ Given the size of the RFP, UHC includes as Exhibit 1, only the cited portion.

copies of each proposal and a document entitled “Attachment #11 PHP Consensus Scoring Excel File REDACTED” (“Attachment 11”), which provided the scoring breakdown for all proposals.

After DHHS announced the Award and provided the offerors with a copy of Attachment 11, among other documents, four disappointed Offerors – Aetna, North Carolina Provider Owned Plans, Inc. d/b/a My Health by Health Providers’ (“My Health”), Optima Family Care of North Carolina (“Optima”), and CCH – filed protests. Aetna filed its protest on March 5, 2019. Aetna’s protest did not challenge UHC’s award—in fact Aetna conceded that if all of Aetna’s protest claims were successful, UHC would have scored the highest among all offerors. (*See Proposed Amended Petition, Exh. A., at p 21.*) DHHS thereafter held protest meetings with each of the protestors, including Aetna on April 4, 2019, and ultimately issued decisions denying all four protests.

On April 16, 2019, Aetna filed a Petition for a Contested Case Hearing (“Petition”) and a Motion for Preliminary Injunction, challenging the Award and seeking a preliminary injunction to stay implementation until this contested case is resolved. Again, nowhere in Aetna’s Petition did it challenge the final score of UHC, or its award of bonus points for Question 11, and again argued that UHC should have earned the most points in the competition. (*See Proposed Amended Petition, Exh. A., generally; see also id. at p 21.*) Following written briefing on Aetna’s Motion for Preliminary Injunction and hours of oral argument between the parties, on June 26, 2019, the Tribunal issued an order denying Aetna’s Motion for Preliminary Injunction, finding that Aetna failed to meet its burden to warrant such relief. Thereafter, the parties proceeded with this contested case, including specifically with discovery, and have conducted numerous depositions from August 19, 2019 to the present.

Now, more than six months after filing its initial protest, and more than five months after filing its initial Petition, Aetna seeks leave to amend its Petition (the “Proposed Amended Petition”) to allege additional facts that Aetna contends were previously unknown and only recently came to light during discovery. With respect to UHC in particular, Aetna seeks leave to allege the following “new” facts: that UnitedHealthcare of North Carolina, Inc., is prohibited from participating in the Federally Facilitated Marketplace (“FFM”) in North Carolina until 2022, and that Aetna recently learned that UHC intends to fulfill its FFM commitment through its affiliate, UnitedHealthcare of Wisconsin (“UHC WI”). Based upon these two facts (only the latter of which Aetna actually did learn recently), Aetna claims that UHC was improperly awarded bonus points for Question 11. (*See* Proposed Amended Petition, at ¶¶152-160, 162, 165.)² However, leave to amend to add these facts is simply not warranted here.

Question 11 of the Request for Proposals (“RFP”) asked offerors to indicate whether they were committed to providing qualified health plans on the FFM. As part of its proposal, UHC responded to this question in the affirmative, stating that it planned to offer coverage on the individual marketplace, and providing its proposed footprint. (*See* Exh. 2, UHC’s Response to Question 11 (Redacted).) Based on such response, DHHS awarded UHC bonus points for its FFM commitment, just as it did for ACNC, BCBS, CCH, Optima, and Wellcare. Ultimately, DHHS announced that UHC was one of four offerors to be awarded a statewide contract.

Aetna does not deny in its proposed Amended Petition that, as reflected in the letter cited, UHC immediately began communicating with the North Carolina Department of Insurance (“DOI”) to fulfill its FFM commitment by January 1, 2021, as required by the RFP. (*See* Exh. 3,

² Why Aetna has sought to amend its Petition in this respect is unclear. Aetna again concedes that UHC is entitled to a statewide contract even without the bonus points from Question 11. (*See* Amended Petition, at ¶ 165.)

July 26, 2019 Letter from UHC to DHHS.)³ As the letter indicates, because UHC had withdrawn from the individual FFM in North Carolina, effective January 1, 2017, UHC intended to participate on the FFM through its North Carolina-licensed affiliate UHC WI, which entity was already a licensed HMO in North Carolina. (*Id.* at 2) Amidst these efforts, on July 23, 2019, UHC received a letter from DHHS inquiring as to whether UHC is able to participate on the FFM in North Carolina in Qualified Health Plan Year 2021 given UHC's 2017 withdrawal. (See Exh. 4, July 23, 2019 Letter from DHHS to UHC.) On July 26, 2019, UHC responded and explained that UHC intends to participate in the FFM in North Carolina through its affiliate UHC WI, and that it expects to submit its application for certificate authority to DOI in August. (Exh. 3, July 26, 2019 Letter from UHC to DHHS.)

A little over a month later, on September 19, 2019, with discovery coming to a close, Aetna filed the instant Motion for Leave, seeking to amend its Petition, to allege, *inter alia*, that DHHS improperly awarded UHC bonus points for Question 11 because UHC is prohibited from re-entering the FFM in North Carolina until 2022. (Proposed Amended Petition, at ¶ 154.) Aetna argues that leave to amend is appropriate because it only “first discovered” this issue on August 19, 2019, when DHHS produced its July 23, 2019 letter to UHC during discovery. (*Id.* ¶ 157.) However, as explained in detail below, Aetna has been well-aware of the material facts for months and in some respects, even years, and yet Aetna took no action as a result. Further, these additional facts fail to state a claim in this case. Accordingly, Aetna's Motion for Leave should be denied as it is futile, unduly delayed, and prejudicial to the other parties.

³ If the Petition to Amend is granted, UHC will be able to prove these incontrovertible facts in a motion for summary judgment, at the hearing. For the reasons stated herein, it would be an unnecessary waste of Tribunal and party resources to require UHC to go through that exercise when Aetna's claim has already been waived and the issue in the light most favorable to Aetna would not change the outcome of the procurement.

LEGAL STANDARD

Courts in North Carolina are instructed to construe Rule 15 motions to amend liberally “to allow amendments where the defense will not be materially prejudiced.” *Members Interior Constr. v. Leader Constr. Co.*, 124 N.C. App. 121, 124, 476 S.E.2d 399, 402 (1996). However, courts have the discretion to deny a motion to amend. *Id.* Reasons justifying the denial of a motion to amend include “(a) undue delay, (b) undue prejudice, and (c) futility of amendment.” *Id.* (citing *Martin v. Hare*, 78 N.C. App. 358, 361, 337 S.E.2d 632, 634 (1985)). Here, all three of these factors weigh in favor of denying Aetna’s Motion for Leave.

ARGUMENT

I. Aetna’s Motion To Amend Is Futile Because Aetna Fails To State A Claim For Relief.

A motion to amend is futile “[w]here the facts alleged in a proposed amendment would not state a claim for relief.” *See Spoor v. Barth*, ___ N.C. App. ___, ___, 811 S.E.2d 609, 615 (2018) (citing *City of Winston-Salem v. Yarbrough*, 117 N.C. App. 340, 347-48, 451 S.E.2d 358, 364 (1994)). Here, Aetna’s Proposed Amended Petition, as related to UHC, does not state a claim for relief. The allegations Aetna seeks to add are not properly before the Tribunal, have been waived, and are wholly irrelevant as they provide no support for Aetna’s contested case, and do not warrant granting Aetna the ultimate relief it seeks, - i.e., a statewide MCO contract or a re-procurement of the RFP.

First, Aetna cannot state a claim that DHHS improperly awarded bonus points to UHC, and indeed OAH lacks jurisdiction to even consider it, because Aetna has not exhausted its administrative remedies with respect to this issue. *See e.g., Abrons Family Practice & Urgent Care, PA v. N. Carolina Dep’t of Health & Human Servs.*, 370 N.C. 443, 453, 810 S.E.2d 224, 231-32 (2018) (dismissing plaintiff’s action for lack of subject-matter jurisdiction due to plaintiffs’

failure to exhaust administrative remedies in seeking damages for denied Medicaid reimbursement claims); *see also id.* at 447 (“A plaintiff’s failure to exhaust administrative remedies may result in the dismissal of the complaint for lack of subject-matter jurisdiction”); *Nichols v. Univ. of N. Carolina at Chapel Hill*, 803 S.E.2d 698 (N.C. App. 2017) (dismissing a petition for contested case where the petitioner failed to exhaust her administrative remedies.)

Section II.G.6 of the RFP provides that any offeror seeking to protest a Contract resulting from this solicitation, “**shall**” submit a written protest within thirty (30) calendar days from the Contract Award, and further states that the protest will be handled following the procedures outlined in 01 NCAC 05B.1519, which likewise provides that “[w]hen an offeror wants to protest a contract awarded by an agency over ten thousand dollars (\$10,000) in value . . . [t]he offeror **shall** submit a written request for a protest meeting . . . within 30 consecutive calendar days from the date of the contract award.” [Emphasis added.] In other words, before an unsuccessful offeror can initiate a contested case proceeding with OAH, it must first submit a written protest to DHHS. Indeed, Aetna concedes as much in its Proposed Amended Petition. (*See* Proposed Amended Petition, at ¶ 10 (asserting, albeit incorrectly, that it has “exhausted its administrative remedies”)).

Here, however, with respect to this additional claim related to UHC, Aetna has **not** exhausted its administrative remedies, as Aetna never raised this issue with DHHS in a timely-submitted protest as it was required to do. Moreover, while exhaustion may not be required under very limited circumstances – e.g., when the remedy would be inadequate – such circumstances do not exist here, and regardless, Aetna has not met its burden to prove that such exhaustion requirement does not apply. *See Frazier v. N.C. Cent. Univ.*, 244 N.C. App. 37, 44, 779 S.E.2d 515, 520 (2015) (noting that “the policy of requiring the exhaustion of administrative remedies prior to the filing of court actions does not require merely the initiation of prescribed administrative

procedures, but that they should be pursued to their appropriate conclusion” and that “[w]hile acknowledging that exhaustion of administrative remedies is not required when the only remedies available from the agency are shown to be inadequate . . . [t]he burden of showing the inadequacy of the administrative remedy is on the party claiming the inadequacy, and the party making such a claim must include such allegation in the complaint” (internal quotations omitted)); *see also Affordable Care, Inc. v. N. Carolina State Bd. of Dental Examiners*, 153 N.C. App. 527, 534, 571 S.E.2d 52, 58 (2002) (holding that where the plaintiffs alleged to have exhausted all administrative remedies by taking some administrative steps without alleging futility nor other facts justifying avoidance of the full administrative process, “plaintiffs failed to carry their burden of establishing exhaustion of all available administrative remedies.”)

As noted above, despite Aetna’s contention that the information related to UHC was only recently discovered, all relevant facts were known (or should have been known) to Aetna for months and even years before filing this Motion for Leave. Aetna knew, or should have known, since **February 2019**, that UHC was awarded bonus points for Question 11– i.e., before it filed its initial protest on March 5, 2019 – because DHHS provided the offerors with a copy of Attachment # 11 on or about February 7, 2019, which included the scoring breakdown for each offeror. Moreover, Aetna knew, or should have known, since **April 2016**, that UHC had withdrawn from the FFM in North Carolina, effective January 1, 2017, because such information was public knowledge.⁴ In fact, Aetna must have been aware of UHC’s FFM withdrawal since Aetna itself

⁴ *See* Dan Way, *Analysts: United Healthcare’s Exit From N.C. Obamacare Exchange Ominous*, Carolina Journal (Apr. 22, 2016), <https://www.carolinajournal.com/news-article/analysts-united-healths-departure-from-n-c-obamacare-exchange-ominous/>; *see also* Katharine Grayson, *UnitedHealthcare to exit nearly all Obamacare exchanges, including in North Carolina*, Triad Business Journal (Apr. 20, 2016), <https://www.bizjournals.com/triad/news/2016/04/20/unitedhealthcare-to-exit-nearly-all-obamacare.html>

was participating in the individual FFM in North Carolina at that time, until it too announced its own withdrawal just a few months later.⁵ Therefore, Aetna should have alleged these facts, if at all, in its initial protest and then again in its initial Petition, but it failed to do so. Aetna has provided no explanation for such failure other than the conclusory allegation that it “first discovered” this issue in August, 2019. (Proposed Amended Petition, at ¶157.) But, that is simply not correct. Accordingly, any attempt by Aetna to argue that such facts only became known to it in August, 2019 and therefore that it was not required to exhaust its administrative remedies, should be rejected out of hand.

Second, along this same vein, Aetna’s Amended Petition fails to state a claim as it relates to UHC because any such claim has been waived by Aetna’s failure to timely assert it when it has been aware of these allegedly “new” facts since at least February, 2019. *See, e.g., United Leasing Corp. v. Miller*, 60 N.C. App. 40, 44, 298 S.E.2d 409, 412 (1982) (“As the material facts were clearly known to plaintiff from the outset, plaintiff’s delay [in amending its complaint] was entirely undue”); *Forstmann v. Culp*, 114 F.R.D. 83, 87 (M.D.N.C. Feb. 13, 1987) (“Many courts have held that where the party seeking an untimely amendment knows or should have known of the facts upon which the proposed amendment is based, but fails to assert them in a timely fashion, the motion to amend is subject to denial”). Aetna never filed a supplemental protest with DHHS and it did not file its Motion for Leave until September 19, 2019. Accordingly, Aetna should not be permitted to raise these new grounds now, as they have been waived as untimely. *See e.g.,*

⁵ *See* Nathan Bomey, *Aetna’s exit deals blow to Obamacare, patients*, USA Today (Aug. 16, 2016), <https://www.usatoday.com/story/money/2016/08/16/aetna-obamacare-affordable-care-act-exchanges/88825798/>; *see also* Amy Goldstein, *In North Carolina, ACA insurer defections leave little choice for many consumers*, Wash. Post (Oct. 14, 2016), https://www.washingtonpost.com/national/health-science/in-north-carolina-aca-insurer-defections-leave-little-choice-for-many-consumers/2016/10/14/770f7bb2-9172-11e6-a6a3-d50061aa9fae_story.html.

Loral Packaging Inc., B-221341, 1986 WL 63371, *4 (Apr. 8, 1986) (dismissing protestor’s new protest grounds as untimely where protestor failed to raise them within the protest time frame (ten working days) after learning of the facts giving rise to the new grounds).⁶

Third, Aetna’s Amended Petition fails to state a claim with respect to UHC, and granting leave would be futile, for the additional reason that DHHS did not improperly award bonus points to UHC. Question 11 entitled offerors to bonus points if the offerors committed to participating in the FFM by 2021. Here, that is exactly what UHC properly did. Although UnitedHealthcare of North Carolina, Inc., is prohibited from participating on the FFM until January 1, 2022 (unless a statutory exception applies), neither North Carolina law, nor federal law bars a properly licensed *affiliate* of UHC from participating. *See, e.g.*, N.C. Gen. Stat. § 58-68-65(c)(2)(b) (prohibiting a “health insurer” from providing for the issuance of health insurance coverage in North Carolina for five years after it has discontinued health insurance coverage on the individual market); *id.* § 58-68-25(a)(6) (defining “health insurer” in relevant part *not* as an affiliated group of insurance companies, but as “an insurance company subject to” Chapter 58 of the North Carolina General Statutes); *see also* 45 C.F.R. §§ 147.106(d)(2) and 148.122(f) (prohibiting an “issuer” (individually, and not its affiliates) that elects to discontinue offering health insurance coverage in the individual, small group, or large group market from issuing coverage in that market for five years following the discontinuation). UHC WI never withdrew from the FFM in North Carolina, and therefore, is not subject to the statutory ban. Further, as UHC explained to DHHS in its July 26, 2019 letter, UHC WI is already licensed in North Carolina and is in the process of expanding

⁶ For the same reason, as no doubt argued by DHHS and BCBS, if not others, the new claim that BCBS should not have received 12.5 reference points for its client reference from BCBS of SC should have been part of Aetna’s initial protest meeting request and petition. Aetna’s claimed movement out of the top four awardees as a result of DHHS’s quality assurance review of references was clear and obvious on the face of Attachment #4, which Aetna received in February.

its license in order to participate on the FFM in the footprint commitment proposed in UHC's response to Question 11. Therefore, UHC will have no issue fulfilling the commitment it made in response to Question 11.

Moreover, Question 11 did not require UHC to identify the entity through which its FFM participation would be accomplished. The Question stated precisely:

The Department is seeking partners to create a more competitive insurance environment in North Carolina and increase access to health care across family units. The Offeror may choose, at its sole discretion, to indicate its commitment to offer Qualified Health Plans (QHPs) in North Carolina on the Federally Facilitated Marketplace (FFM) in QHP Plan Year 2021. Commitment to offer QHPs on the FFM is defined as timely submitting all necessary NCDOT-related regulatory submissions (including rates and policy forms) and QHP application to the FFM in the Spring of 2020 (or within whatever time frames NC DOT and the FFM establish), and committing to actively seek all required state and federal approvals to offer QHPs.

The Offeror may choose to indicate its commitment to participating in the FFM by outlining current Marketplace participation in North Carolina and other states and expected FFM footprint in North Carolina in 2021.

A commitment to offer QHPs in North Carolina on the FFM is optional and, if made, worth bonus points. An Offeror which does not make this commitment would not be awarded bonus points.

(Exh. 1, RFP, Attachment O, at p. 15.) Therefore, UHC's answer to Question 11 was not inaccurate or misleading. UHC committed to participating in the FFM and it remains committed to this day. And, nothing in Question 11 prohibited affiliates from satisfying the commitment. In fact, by way of only one example, ACNC likewise intends to participate on the FFM through an affiliate, Independence Health Group. (See Exh. 5, ACNC's Response to Question 11.) ACNC was awarded bonus points as a result. Similarly, two other offerors sought and were awarded bonus points when their respective proposals referred to FFM participation by an affiliate (or alleged affiliate) of the offeror rather than the offeror itself. (See e.g., Exh. 6, CCH's Clarification

Response to Question 11.) Therefore, the award of bonus points to UHC for such commitment was entirely proper as a matter of law, and DHHS did not “exceed[] its authority, act[] arbitrarily and capriciously, use[] improper procedure, [or] fail[] to act as required by law” in awarding bonus points to UHC for its response to Question 11. (*See* Proposed Amended Petition, at ¶162.)

Finally, Aetna’s Motion for Leave should be denied as futile for the additional reason that Aetna’s “new” allegations would not change the outcome of the Contract Award. As awarded, UHC received 727.76474 points, coming in second place. (Proposed Amended Petition, ¶ 48.) Even if OAH were to conclude that UHC was improperly awarded any bonus points for Question 11, and that such points must be subtracted from UHC’s total, UHC would have received 708.66399 points. Therefore, Aetna’s proposed new claim does not impact Aetna’s ability to receive an award. (*See* Proposed Amended Petition, at ¶ 48). In fact, by Aetna’s own calculations, even if OAH accepts all of Aetna’s arguments related to UHC, UHC would still be awarded a statewide contract. (*See* Proposed Amended Petition, at ¶ 165.) Accordingly, the “new” allegations related to UHC are entirely immaterial to the outcome of this case and do not state a claim for relief. *See Newton v. Standard Fire Ins. Co.*, 291 N.C. 105, 111, 229 S.E.2d 297, 300 (1976) (affirming the trial court’s decision dismissing a claim for failure to state a claim for relief and striking the allegations supporting that claim as immaterial).

For all the above reasons, the futility of Aetna’s Motion for Leave as it relates to its allegations and claims regarding UHC is evident – *as a matter of law* UHC’s proposed utilization of UHC WI entitled it to Question 11 bonus points; and also, Aetna waived its right to make this claim, and has failed to exhaust its administrative remedies. In order to avoid an unnecessary waste of resources in a motion for summary judgment that would clearly be successful, or at the

hearing itself, the Tribunal should deny Aetna's Motion for Leave, at least as it relates to adding additional allegations relating to UHC.

II. Aetna's Attempt To Amend Its Petition Two Weeks Before Discovery Closes Is Unduly Delayed.

A trial court may also deny motions to amend due to "undue delay." In determining whether there has been undue delay, the court "may consider the relative timing of the proposed amendment in relation to the progress of the lawsuit." *Draughon v. Harnett Cty. Bd. of Educ.*, 166 N.C. App. 464, 467, 602 S.E.2d 721, 724 (2004); *see also Global Textile All., Inc. v. TDI Worldwide, LLC*, No. 17 CVS 7304, 2018 WL 1720822, at *4 (N.C. Super. Ct. Apr. 6, 2018). Stated another way, a court may deny a motion to amend "where a party seeks to amend its pleading after a significant period of time has passed since filing the pleading and where the record or party offers no explanation for the delay." *Rabon v. Hopkins*, 208 N.C. App. 351, 354, 703 S.E.2d 181, 184 (2010).

Aetna initiated this contested case on March 5, 2019. Since then, significant discovery has taken place, thousands of documents have been produced, and numerous depositions have been conducted. Now, with essentially two weeks left before discovery is set to close, Aetna is bringing this Motion for Leave, seeking to allege additional facts related to UHC that Aetna has known for months, and in some instances, even years. Although Aetna claims that UHC's withdrawal from the marketplace was "first discovered" when DHHS's July 23, 2019 letter to UHC was produced on August 19, 2019, this does not negate the fact that Aetna should have been aware of UHC's withdrawal from the individual marketplace in North Carolina in 2016, and should have known that UHC received bonus points in February, 2019. Aetna has provided no explanation for its failure to raise these issues in its original protest or its original Petition despite its knowledge of all the material facts at those times. Aetna's inexplicable and unjustified delay should not be

rewarded by the granting of its Motion for Leave. *See Willoughby v. Johnston Mem. Hosp. Auth.*, 791 S.E.2d 283, 2016 WL 4091370, * 6 (N.C. App. 2016) (denying motion for leave to amend for undue delay where “Johnston Health provided no explanation for its delay in seeking to amend the third-party complaint.”); *Wilkerson v. Duke Univ.*, 229 N.C. App. 670, 679, 748 S.E.2d 154, 161 (2013) (affirming trial court’s denial of a motion to amend that plaintiffs filed only five days before the hearing on the defendants’ motion for summary judgment).

Furthermore, if the proposed amendments would require “additional or different discovery” and thus would “slow the litigation process[] and present a more unwieldy litigation for the trial court to administrate,” the trial court may deny the motion to amend. *Global Textile All.*, No. 17 CVS 7304, 2018 WL 1720822, at *4 (N.C. Super. Apr. 6, 2018) (quoting *Stetser v. TAP Pharm. Prods. Inc.*, 165 N.C. App. 1, 31, 598 S.E.2d 570, 590 (2004)). Therefore, to the extent that Aetna seeks to pursue additional discovery regarding the FFM bonus points or any other allegations in its Proposed Amended Petition, OAH should deny the Motion for Leave as an attempt to delay the resolution of this case by attempting to extend the discovery period at the eleventh hour.

III. Aetna’s Motion To Amend Is Prejudicial To The Parties At This Stage In The Case.

Finally, if a motion to amend will be unduly prejudicial to the defendants, the trial court may deny the motion. *See Global Textile All.*, 2018 WL 1720822, at *4. For example, North Carolina courts have found motions to amend to be unduly prejudicial: (1) if the amended petition would “involve more discovery for the parties, slow the litigation process, and present a more unwieldy litigation for the trial court to administrate” (*id.*); and (2) when a motion to amend occurs “late into the proceedings” and is “based substantially on information that [plaintiff] possessed” for some time prior to filing the motion. *Willoughby*, 2016 WL 4091370, at *8.

Here, UHC would be unduly prejudiced if the Motion for Leave is granted this late in the litigation. Requiring UHC and the other parties to respond to and litigate a new petition right as discovery is scheduled to close undoubtedly slows the litigation process and might cause the extension of discovery yet again. Furthermore, as explained in detail above, Aetna's allegations regarding UHC's bonus points under Question 11 are comprised of information that Aetna has had access to for months, and in the case of UHC's withdrawal, for years. Aetna's claim that it "first discovered" that UnitedHealthcare of North Carolina, Inc. was arguably barred from FFM participation until 2022 when DHHS produced its July 23, 2019 letter to UHC is simply untrue, and does not adequately explain its failure to address its concerns regarding the award of bonus points to UHC earlier in this case.

CONCLUSION

For all the reasons set forth above, UHC respectfully requests that this Court deny Aetna's Motion for Leave to Amend Its Petition for a Contested Case Hearing.

This is the 4th day of October, 2019.

/s/ F. Hill Allen

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CERTIFICATE OF SERVICE

I hereby certify that I have this day served a copy of the foregoing **UNITEDHEALTHCARE OF NORTH CAROLINA, INC.'S MEMORANDUM IN OPPOSITION TO AETNA BETTER HEALTH OF NORTH CAROLINA INC.'S MOTION FOR LEAVE TO AMEND ITS PETITION FOR A CONTESTED CASE HEARING** on the following parties by electronic mail:

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This the 4th day of October, 2019.

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Exhibit 1

Section VIII. Attachment O.

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Attachment O. Offeror's Proposal and Response Table 5: Managed Care Contract Termination, Non-Renewal, Withdrawal, or Enrollment Level Reduction in the past 15 years	
Was the contract terminated/non-renewed based on the Offeror's performance?	
If answered 'Yes' to the question above, describe any corrective actions taken to prevent future occurrence of the problem leading to the termination/non-renewal. If answered 'No' to the question above, insert 'N/A'	
Was the violation the subject of an administrative proceeding or litigation?	
If answered 'Yes' to the question above, indicate the result of the proceeding/litigation. If answered 'No' to the question above, insert 'N/A'	

Evaluation Question	
10.	<p>The Offeror shall disclose all sanctions imposed against the Offeror as part of a managed care contract in the past seven (7) years in the <i>Attachment O. Offeror's Proposal and Response Table 6: Disclosure of Imposed Sanctions as part of a Managed Care Contract in Past 7 Years</i>. For the purposes of this question, a sanction shall include any monetary penalty, including e.g., civil monetary penalty or liquidated damage. The Offeror's response shall include information for the Offeror as well as all entities identified as performing a Core Medicaid Operations Function in Question #5.</p> <ul style="list-style-type: none"> a. If imposed, describe the nature of the sanction, the underlying action leading to the sanction, the market in which the sanction was imposed, and the assessed monetary amount (if applicable). b. Describe any corrective actions taken to prevent any future occurrence of the problem leading to the sanction(s). c. If the sanction(s) was the subject of an administrative proceeding or litigation, indicate the result of the proceeding/litigation. <p>Offeror must fill out 1 table for each imposed sanction. Completed tables shall not be counted toward the Offeror's total page guidelines.</p>
Response	

Attachment O. Offeror's Proposal and Response Table 6: Disclosure of Imposed Sanctions as part of a Managed Care Contract in Past 7 Years	
Entity (as identified in Question #5)	
Type of Contract	
Services Provided	
Describe the nature of the sanction	
Describe the underlying action leading to the sanction	
Describe the market in which the sanction was imposed	
Describe the assessed monetary amount, if applicable	

Describe the corrective actions taken to prevent any future occurrence of the problem leading to the sanction(s)	
Was the sanction the subject of an administrative proceeding or litigation?	
If answered 'Yes' to the question above, indicate the result of the proceeding/litigation. If answered 'No' to the question above, insert 'N/A'	

Evaluation Question	
11.	<p>The Department is seeking partners to create a more competitive insurance environment in North Carolina and increase access to health care across family units. The Offeror may choose, at its sole discretion, to indicate its commitment to offer Qualified Health Plans (QHPs) in North Carolina on the Federally Facilitated Marketplace (FFM) in QHP Plan Year 2021. Commitment to offer QHPs on the FFM is defined as timely submitting all necessary NCDOL-related regulatory submissions (including rates and policy forms) and QHP application to the FFM in the Spring of 2020 (or within whatever time frames NC DOI and the FFM establish), and committing to actively seek all required state and federal approvals to offer QHPs.</p> <p>The Offeror may choose to indicate its commitment to participating in the FFM by outlining current Marketplace participation in North Carolina and other states and expected FFM footprint in North Carolina in 2021.</p> <p>A commitment to offer QHPs in North Carolina on the FFM is optional and, if made, worth bonus points. An Offeror which does not make this commitment would not be awarded bonus points.</p>
Response	
Detail any limitations and / or issues meeting the Department's expectations or requirements related to this response. No response will be interpreted as no limitations or issues.	

Exhibit 2

Redacted

Evaluation Question	
11.	<p>The Department is seeking partners to create a more competitive insurance environment in North Carolina and increase access to health care across family units. The Offeror may choose, at its sole discretion, to indicate its commitment to offer Qualified Health Plans (QHPs) in North Carolina on the Federally Facilitated Marketplace (FFM) in QHP Plan Year 2021. Commitment to offer QHPs on the FFM is defined as timely submitting all necessary NCDOL-related regulatory submissions (including rates and policy forms) and QHP application to the FFM in the Spring of 2020 (or within whatever time frames NC DOI and the FFM establish), and committing to actively seek all required state and federal approvals to offer QHPs.</p> <p>The Offeror may choose to indicate its commitment to participating in the FFM by outlining current Marketplace participation in North Carolina and other states and expected FFM footprint in North Carolina in 2021.</p> <p>A commitment to offer QHPs in North Carolina on the FFM is optional and, if made, worth bonus points. An Offeror which does not make this commitment would not be awarded bonus points.</p>
Response	
<p>As a part of our commitment to serve the citizens of North Carolina and living our mission to help people live healthier lives and make the health system work better for everyone, UnitedHealthcare intends to offer qualified health plans (QHPs) in North Carolina on the Federally Facilitated Marketplace (FFM) in QHP Plan Year 2021.</p> <p>UnitedHealthcare currently participates in the individual Marketplace in the following states: Colorado, Nevada and New York. For Plan Year 2019, we have also filed to participate in the</p>	

individual Marketplace in Massachusetts.

Redacted

Detail any limitations and / or issues meeting the Department's expectations or requirements related to this response. No response will be interpreted as no limitations or issues.

We affirm there are no limitations or issues meeting the Department's expectations or requirements related to this response.

Exhibit 3

CONFIDENTIAL / PUBLIC RECORDS LAW EXEMPT / FOIA EXEMPT

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Re: NC Dept. of Health & Human Services RFP # 30-190029-DHB

Dear Bob:

This letter responds to your correspondence of July 23, 2019, regarding the response by UnitedHealthcare of North Carolina, Inc. ("UHCNC") to Evaluation Question 11 of RFP No. 30-190029-DHB related to an offeror's commitment to offer Qualified Health Plans ("QHP") in North Carolina on the Federally Facilitated Marketplace ("FFM") in plan year 2021. As explained in greater detail below, UHCNC answered Question 11 truthfully and accurately, and through its North Carolina-licensed affiliate, UnitedHealthcare of Wisconsin, Inc., has already taken steps to provide coverage in the FFM for North Carolina in QHP plan year 2021.

As noted in your letter, UHCNC and UnitedHealthcare Life Insurance Company both exited the individual market, effective January 1, 2017. As further noted in your letter, under N.C.G.S. § 58-68-65(c)(2)(b), unless an exception applies, health insurers who have discontinued offering all health insurance coverage in the individual market in North Carolina generally cannot reenter that market in the State for five years after the date of discontinuation.

Notably, UnitedHealthcare was clear in its April 14, 2016 Notice of Individual Market Exit and Non-Participation in Individual Exchange for 2017, that the exit of UHCNC and

Alston & Bird LLP

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LEGAL02/39121955v1



NCDHHS-0212030

July 26, 2019

Page 2

UnitedHealthcare Life Insurance Company from the individual market did not impact any other UnitedHealthcare licenses, products, or segments (individual, small group, and large group). Accordingly, the law does not prevent UnitedHealthcare of Wisconsin from participating in the North Carolina individual market.

UnitedHealthcare of Wisconsin is already a licensed HMO in North Carolina. [See attached.] The North Carolina Department of Insurance ("NCDOI") is well-aware of UnitedHealthcare's intent to add the North Carolina individual market to UnitedHealthcare of Wisconsin's license, as UnitedHealthcare began discussions with NCDOI regarding the issue immediately following award. UnitedHealthcare expects to submit its application for certificate authority to NCDOI by mid-August, and does not anticipate any issues with its application.

With respect to Evaluation Question 11, nothing in the RFP required identification of the entity through which FFM participation would be accomplished, and certainly nothing UHCNC stated in response to Evaluation Question 11 was inaccurate or misleading. It was certainly reasonable for UHCNC to assume that both NCDOI and the Department of Health and Human Services were well aware of UHCNC's withdrawal in 2016. In any event, UnitedHealthcare looks forward to growing its presence in North Carolina, across multiple product lines.

Because this letter and its attachments contain confidential and/or trade secret information, UHCNC hereby designates this letter and its attachments as materials that are exempt from disclosure under the North Carolina Public Records laws, N.C.G.S. § 132-1, *et seq.*, and the Freedom of Information Act, 5 U.S.C. § 552, *et seq.* UHCNC requests that it be provided prompt written notice sufficiently in advance of any disclosure to enable UHCNC to respond appropriately and otherwise seek protection of this information.

Please let us know if you need any further information.

Sincerely,



NUMBER: 112478

Initial Effective Date: April 08, 2015

UnitedHealthcare of Wisconsin, Inc.

a Health Maintenance Organization Domiciled in Wisconsin

nc: has complied with the necessary requirements pursuant to Chapter 58 of the North Carolina General
provisions of the laws of this State, the following kinds of insurance, as defined in Article 67:

rvices in the
pproved and on file

Restricted to Medicare Business only. Coverage area includes all
counties in North Carolina.

and in effect, subject to timely payment of the annual license continuation fee in accordance with N.C.G.S. 58-67-160
e provision of the insurance laws of this state.



Wynne Daniels
Commissioner Of Insurance

DESIGNATION:

LIFE INSURANCE

CASUALTY INSURANCE

- [illegible]

FIRE INSURANCE

Exhibit 4

HAYNSWORTH SINKLER BOYD

HAYNSWORTH SINKLER BOYD, P.A.
1201 MAIN STREET, 22ND FLOOR
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COLUMBIA, SOUTH CAROLINA 29201
MAIN 803.779.3080
FAX 803.765.1243
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ROBERT Y. KNOWLTON
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bknowlton@hsblawfirm.com

July 23, 2019

VIA E-MAIL ONLY

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Jeff.Belkin@alston.com

Jeffrey A. Belkin, Esq.
Alston & Bird
1201 West Peachtree Street NW, Suite 4900
Atlanta, GA 30309

Re: NC Dept. of Health & Human Services RFP # 30-190029-DHB

Dear Hill and Jeff:

As you know, this firm represents the North Carolina Department of Health and Human Services in connection with the above procurement, and I am sending this letter to you in your capacity as counsel for UnitedHealthcare of North Carolina, Inc.

Evaluation Question 11 set forth in Section VIII, Attachment O of the Request for Proposals asked offerors to indicate whether they would commit to offer Qualified Health Plans in North Carolina on the Federally Facilitated Marketplace (FFM) in Qualified Health Plan Year 2021 and, if so, in what footprint. In addition, offerors were asked to detail any limitations or issues meeting the Department's expectations or requirements related to this response. United Healthcare responded that it would offer qualified health plans in North Carolina on the FFM in plan year 2021.

However, it appears that UnitedHealthcare withdrew from the FFM marketplace in North Carolina effective January 1, 2017. (See April 14, 2016 letter to Wayne Goodwin, attached.) Pursuant to N.C.G.S. Section 58-68-65(c)(2)(b), insurers are prohibited from reentering this market for a five-year period beginning on the date of discontinuation of the last health insurance coverage not so renewed.

If UnitedHealthcare contends that it would not be prohibited from providing coverage in the FFM market for North Carolina in Qualified Health Plan Year 2021, please explain why not. Also, please explain why this information was not disclosed in UnitedHealthcare's response to RFP Evaluation Question 11.

**HAYNSWORTH
SINKLER BOYD**

F. Hill Allen, Esq.
Jeffrey A. Belkin, Esq.
July 23, 2019
Page 2

We request a response as soon as practicable but no later than noon on July 26, 2019.

Sincerely yours,



Robert Y. Knowlton
RYK/bev
Enclosure



UnitedHealthcare

Garland G. Scott, CEO
UnitedHealthcare South Atlantic
(Carolinas and Georgia)
3803 North Elm Street
Greensboro, NC 27455
336-540-7552

April 18, 2016

Wayne Goodwin
Insurance Commissioner & State Fire Marshal
Dobbs Building
430 N. Salisbury Street
Raleigh NC 27603-5926

BY HAND DELIVERY

RE: Notice of Individual Market Exit and Non-Participation in Individual Exchange for 2017

Dear Commissioner Goodwin:

We are providing you with this formal notice of our intention to effectuate an individual market exit effective 1/1/2017, consistent with North Carolina state law and in federal rules under 45 CFR § 147.106(d), and 148.122(e), as well as our decision not to participate on the Individual exchange for 2017. The specific licenses impacted are outlined below.

UnitedHealthcare of North Carolina, Inc. – Individual market exit to take effect on 1/1/17 with notice to current enrollees a minimum of 180 days (mailed no later than 7/1/16) prior to 1/1/17. Consequently, we will not participate in the Individual Exchange for coverage dates in 2017.

UnitedHealthcare Life Insurance Company - Individual market exit to take effect on 1/1/17 with notice to current enrollees a minimum of 180 days (mailed no later than 7/1/16) prior to 1/1/17.

This notice of our individual market exit, and Individual Exchange non-participation decision, does not impact any other UnitedHealthcare licenses, products, or segments (individual, small group, and large group) not expressly referenced above.

We have attached draft copies of the enrollee 180 day market exit notices (one version for Individual Exchange and the other for Individual non-Exchange enrollees) for your review as Attachments 1 & 2.

If you have any additional questions or require any additional information from us prior to us effectuating the above referenced individual market exit and Individual Exchange non-participation actions, please feel free to contact me at (336) 540-7552.

Sincerely,

Garland G. Scott, CEO
UnitedHealthcare of North Carolina, Inc.

Exhibit 5

Evaluation Question	
10.	<p>The Offeror shall disclose all sanctions imposed against the Offeror as part of a managed care contract in the past seven (7) years in the <i>Attachment O. Offeror's Proposal and Response Table 6: Disclosure of Imposed Sanctions as part of a Managed Care Contract in Past 7 Years</i>. For the purposes of this question, a sanction shall include any monetary penalty, including e.g., civil monetary penalty or liquidated damage. The Offeror's response shall include information for the Offeror as well as all entities identified as performing a Core Medicaid Operations Function in Question #5.</p> <ul style="list-style-type: none"> a. If imposed, describe the nature of the sanction, the underlying action leading to the sanction, the market in which the sanction was imposed, and the assessed monetary amount (if applicable). b. Describe any corrective actions taken to prevent any future occurrence of the problem leading to the sanction(s). c. If the sanction(s) was the subject of an administrative proceeding or litigation, indicate the result of the proceeding/litigation. <p>Offeror must fill out 1 table for each imposed sanction. Completed tables shall not be counted toward the Offeror's total page guidelines.</p>
Response	

Per the response provided to Question #8 (Section VIII. Attachment O Questions) on Page 65 of **Addendum 6: RFP 30-190029-DHB Department Response to Offeror Questions**, AmeriHealth Caritas North Carolina has included detailed tables for all above-listed entities in **Attachment Q10-1_Table 6 Disclosure of Imposed Sanctions as part of Managed Care Contract in the Past 7 Years**.

Evaluation Question	
11.	<p>The Department is seeking partners to create a more competitive insurance environment in North Carolina and increase access to health care across family units. The Offeror may choose, at its sole discretion, to indicate its commitment to offer Qualified Health Plans (QHPs) in North Carolina on the Federally Facilitated Marketplace (FFM) in QHP Plan Year 2021. Commitment to offer QHPs on the FFM is defined as timely submitting all necessary NCDOI-related regulatory submissions (including rates and policy forms) and QHP application to the FFM in the Spring of 2020 (or within whatever time frames NC DOI and the FFM establish), and committing to actively seek all required state and federal approvals to offer QHPs.</p> <p>The Offeror may choose to indicate its commitment to participating in the FFM by outlining current Marketplace participation in North Carolina and other states and expected FFM footprint in North Carolina in 2021.</p> <p>A commitment to offer QHPs in North Carolina on the FFM is optional and, if made, worth bonus points. An Offeror which does not make this commitment would not be awarded bonus points.</p>

Response
<p>AmeriHealth Caritas North Carolina commits to offering a participating Qualified Health Plan (QHP) on the Federally Facilitated Marketplace in QHP Plan Year 2021 in order to foster a more competitive insurance environment and promote continuity of care as Members transition from one program eligibility category to another. AmeriHealth Caritas North Carolina will leverage the extensive knowledge, experience, and best practices of our ultimate parent organization, Independence Health Group, while delivering a Marketplace solution tailored to address the specific needs and nuances of North Carolina.</p> <p>INDEPENDENCE HEALTH GROUP COMMITMENT TO AFFORDABLE CARE ACT</p> <p>Independence Health Group entered the Affordable Care Act market with the inception of the law in 2013 and has been a consistent presence since. Despite competitors entering and exiting, Independence Health Group has participated every year with minimal disruption in plan designs or offerings and is currently participating in 26 counties across Pennsylvania and New Jersey with more than 300,000 members as of June 30, 2018.</p> <p>Plan Offerings</p> <p>Since 2013, Independence Health Group has offered plans both through the Federal Marketplace and directly from the carrier and across all metallic tiers. Their innovative plan designs include tiered networks to ensure competitive price points with low out-of-pocket costs and we strive to deliver products that are both economical to own and economical to use.</p> <p>Consumer Engagement Experience Can be Leveraged in North Carolina</p> <ul style="list-style-type: none"> • Understanding the purchasing of health care is a complicated and challenging process for many consumers, Independence Health Group has demonstrated a long-standing commitment to health care consumers, through education and support during their purchasing process, renewal and ongoing usage. For example Independence Health Group: • Distributed over 50,000 "Health Care Law and You" books, including to local legislators, hospitals, and places of worship. • Partners with local community influencers such as cultural and faith-based organizations to promote education and awareness. • Conducts mobile sales and renewal seminars throughout the community, all staffed with licensed agents. • Provides telephonic access to over 200 licensed agents during the Open Enrollment period. • Helps consumers choose the plan that is right for them through the online guided shopping experience. • Developed EZButton functionality to help Members renew in their same plan with a single tap. • Offers individually customized renewal kits to provide accurate financial information as well as suggested alternative plan choices, including relevant information to help Members transition from Affordable Care Act to Medicaid where appropriate. • Provides comprehensive onboarding communications, educates Members on their plans and how to use them. • Communicates through digital messaging throughout the year to help Members maximize their benefits and manage health conditions.

AmeriHealth Caritas North Carolina understands and is fully prepared to comply with the necessary application process and filing deadlines necessary for certification as a QHP by CMS for the 2021 Plan Year, including application submission and rate filings through the Health Insurance Oversight System (HIOS) and the System for Electronic Rate and Form Filing (SERFF). AmeriHealth Caritas North Carolina also recognizes North Carolina Department of Insurance request for 90-day review of any associated form, rate and binder submissions in advance of the federal filing due date and will comply with any NCDOI timeframes. AmeriHealth Caritas North Carolina will leverage the extensive experience of Independence Health Group in implementing its QHP.

Detail any limitations and / or issues meeting the Department's expectations or requirements related to this response. No response will be interpreted as no limitations or issues.

AmeriHealth Caritas North Carolina does not have any limitations or issues with meeting the Department's expectations or requirements related to this response.

Exhibit 6

Offeror Name: Carolina Complete Health, Inc.

**State of North Carolina
Department of Health and Human Services**

REQUEST FOR CLARIFICATION #1

Date: November 29, 2018

RFP Number: 30-190029-DHB

RFP Description: Prepaid Health Plans

Response Date/Time: December 3, 2018 by 2:00 PM ET

Instructions:

1. Pursuant to reviewing Offeror proposals related to the Request for Proposal referenced above, the Department requires clarification(s) on your response.
2. Review the questions below and provide written answers.
3. Email one properly executed copy of this Request for Clarification #1 to Kimberley Kilpatrick, at Kimberley.Kilpatrick@dhhs.nc.gov, by **2:00 PM ET on December 3, 2018**. Failure to sign and return this request may result in the rejection of your proposal.
4. If you have any questions regarding this request, contact Kimberley Kilpatrick at Kimberley.Kilpatrick@dhhs.nc.gov or (919) 527-7015.

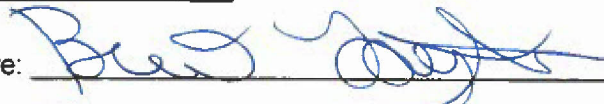
Execute Request for Clarification #1

Offeror: Carolina Complete Health, Inc.

Authorized Signature: _____

Name and Title (Print): _____

Date: _____


BRENT LAYTON EXECUTIVE VICEPRESIDENT
BUSINESS DEVELOPMENT

11/30/18

Questions

In response to Evaluation Question #11, Carolina Complete Health, stated that its affiliate, Ambetter of North Carolina, will operate as a Qualified Health Plan in Wake and Durham counties beginning in January 2019. In addition. The response also provides, "We are committed to expanding our marketplace presence in North Carolina and continue to build our Marketplace network to be statewide by 2021."

Check the appropriate statements:

The Department seeks to clarify the entity referred to by "we" and "our".

The reference is to Ambetter of North Carolina: ☒yes ☐no

The reference is to Carolina Complete Health: ☒yes ☐no

Does the response to this Clarification #1 contain confidential information? ☐yes ☒no

Is a redacted version being submitted? ☐yes ☒no

Written Response:

* Carolina Complete Health (CCH) and Ambetter of North Carolina (Ambetter) are both under common control as subsidiaries of Centene Corporation. Accordingly, as affiliated companies, CCH and Ambetter are both committed to expanding our Marketplace presence in North Carolina. Although the timing of entry into North Carolina for the Marketplace in 2019 required that CCH and Ambetter be two separately licensed entities, CCH, in conjunction with our joint venture partner, Carolina Complete Health Network, has been actively working with Ambetter to contract a network for Marketplace and Medicaid products. For example, CCH has agreements with Duke and WakeMed that include Marketplace (Ambetter) product attachments.

If CCH is fortunate to be awarded a statewide contract under this RFP, CCH intends to expand our Marketplace presence to be statewide by 2021 alongside our Medicaid business. Ambetter's license will be brought under CCH's control and branding as is the case in other Centene Medicaid states.

STATE OF NORTH CAROLINA

IN THE OFFICE OF
ADMINISTRATIVE HEARINGS

COUNTY OF WAKE

Optima Family Care of North Carolina, Inc.,
Petitioner,

v.

North Carolina Department of Health and
Human Services, Mandy Cohen, M.D., MPH,
in her official capacity as Secretary of the
Department, and Dave Richard in his official
capacity as Deputy Secretary of the
Department for NC Medicaid,

Respondent.

and

WellCare of North Carolina, Inc., Blue Cross
And Blue Shield of North Carolina,
AmeriHealth Caritas of North Carolina, Inc.,
UnitedHealthCare of North Carolina, Inc.,
Carolina Complete Health, Inc., and North
Carolina Provider owned Plans, Inc. d/b/a My
Health by Health Providers,

Respondent-Intervenors.

19 DHR 01959

North Carolina Provider Owned Plans, Inc.
d/b/a My Health By Health Providers,
Petitioner,

v.

North Carolina Department of Health and
Human Services,

Respondent.

and

UnitedHealthCare of North Carolina, Inc.,
Blue Cross And Blue Shield of North
Carolina, WellCare of North Carolina, Inc.,
AmeriHealth Caritas of North Carolina, Inc.,
Carolina Complete Health, Inc., and Optima
Family Care of North Carolina, Inc.,

Respondent-Intervenors

19 DHR 02032

Aetna Better Health of North Carolina, Inc.,
d/b/a Aetna Better Health of North Carolina,
Petitioner,

v.

State Of North Carolina Department of Health
and Human Services – Division of Health
Benefits,

Respondent,

and

WellCare of North Carolina, Inc., Blue Cross
And Blue Shield of North Carolina,
AmeriHealth Caritas of North Carolina, Inc.,
UnitedHealthCare of North Carolina, Inc.,
Carolina Complete Health, Inc., and North
Carolina Provider Owned Plans, Inc. d/b/a My
Health By Health Providers,
Respondent-Intervenors.

19 DHR 02194

Carolina Complete Health, Inc.,
Petitioner,

v.

North Carolina Department of Health and
Human Services,

Respondent,

And

AmeriHealth Caritas of North Carolina, Inc.,
and North Carolina Provider Owned Plans,
Inc. d/b/a My Health By Health Providers,
Respondent-Intervenors.

19 DHR 03352

**STATUS REPORT OF AETNA BETTER HEALTH OF NORTH CAROLINA, INC. d/b/a
AETNA BETTER HEALTH OF NORTH CAROLINA AND THE NORTH CAROLINA
DEPARTMENT OF HEALTH AND HUMAN SERVICES**

Pursuant to Paragraph 5(d) in the Tribunal’s Memorandum of Discovery Conference and Order of September 26, 2019, Petitioner Aetna Better Health of North Carolina, Inc. d/b/a Aetna Better Health of North Carolina (“Aetna”) and Respondent the North Carolina Department of Health and Human Services (“the Department”) submit the below status report:

1. On September 20, 2019, Aetna addressed several discovery issues in an e-mail to the Department, including its request that the Department provide complete electronic copies (inclusive of all versions and metadata) of scoring documents as they were created and maintained during the evaluation process. The Department responded to Aetna's e-mail on September 23, 2019.
2. During the course of the discovery conference held in this matter on September 25, 2019, Aetna made a request for the metadata associated with the tab in a spreadsheet that was produced in pdf form on September 4, 2019, and became Deposition Exhibit 113. The native spreadsheet itself contains information that is proprietary and confidential to one or more offerors and is not covered by the terms of the Protective Order entered in this matter.
3. Since September 25, 2019, litigation support personnel for both Aetna and the Department have conferred, as have attorneys for Aetna and the Department, regarding the metadata available in the native spreadsheet that can be extracted and provided to counsel for Aetna.
4. The Department has provided Aetna with printouts of all available metadata from the native spreadsheet that includes the individual tab that became Deposition Exhibit 113. Separate metadata is not available for the individual tab of the spreadsheet that became Deposition Exhibit 113.
5. The Department has provided Aetna with printouts of all available metadata from the 10 other iterations of the native spreadsheet at issue that were maintained in the Department's Sharepoint library in the ordinary course of the Department's business. The metadata printouts for all 11 spreadsheets at issue contain the same fields of metadata information.
6. The available metadata associated with the spreadsheet standing alone does not contain the full amount of information regarding that document's history that Aetna has requested. Aetna has

accordingly requested a file manipulation history chart or similar report that would identify more detailed information associated with the spreadsheet to the extent available from the Department's document management system, such as who accessed/modified the document(s) and when. Accordingly, Department IT personnel and, to the extent necessary, its contractors, are currently evaluating and investigating what, if any, additional information is available in the Department's backend systems.

7. Aetna and the Department are continuing to communicate and work through these issues. The Department will communicate to Aetna the results of the Department's investigation.

(Signature Block on Next Page)

Respectfully submitted,

**JOSHUA H. STEIN
ATTORNEY GENERAL**

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October 4, 2019

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*Counsel for Petitioner Aetna Better Health of
North Carolina Inc., d/b/a Aetna Better
Health of North Carolina*

STATE OF NORTH CAROLINA
COUNTY OF WAKE

IN THE OFFICE OF
ADMINISTRATIVE HEARINGS

Optima Family Care of North Carolina, Inc.,
Petitioner,

v.

North Carolina Department of Health and
Human Services, Mandy Cohen, M.D., MPH,
in her official capacity as Secretary of the
Department, and Dave Richard in his official
capacity as Deputy Secretary of the
Department for NC Medicaid,

Respondent,

and

WellCare of North Carolina, Inc., Blue Cross
And Blue Shield of North Carolina,
AmeriHealth Caritas of North Carolina, Inc.,
UnitedHealthCare of North Carolina, Inc.,
Carolina Complete Health, Inc., and North
Carolina Provider owned Plans, Inc. d/b/a My
Health by Health Providers,

Respondent-Intervenors.

19 DHR 01959

North Carolina Provider Owned Plans, Inc.
d/b/a My Health By Health Providers,
Petitioner,

v.

North Carolina Department of Health and
Human Services,

Respondent,

and

UnitedHealthCare of North Carolina, Inc.,
Blue Cross And Blue Shield of North
Carolina, WellCare of North Carolina, Inc.,
AmeriHealth Caritas of North Carolina, Inc.,
Carolina Complete Health, Inc., and Optima
Family Care of North Carolina, Inc.,

Respondent-Intervenors

19 DHR 02032

Aetna Better Health of North Carolina, Inc.,
d/b/a Aetna Better Health of North Carolina,
Petitioner,

v.

State Of North Carolina Department of Health
and Human Services – Division of Health
Benefits,

Respondent,

and

WellCare of North Carolina, Inc., Blue Cross
And Blue Shield of North Carolina,
AmeriHealth Caritas of North Carolina, Inc.,
UnitedHealthCare of North Carolina, Inc.,
Carolina Complete Health, Inc., and North
Carolina Provider Owned Plans, Inc. d/b/a My
Health By Health Providers,
Respondent-Intervenors.

19 DHR 02194

Carolina Complete Health, Inc.,
Petitioner,

v.

North Carolina Department of Health and
Human Services,

Respondent,

and

AmeriHealth Caritas of North Carolina, Inc.,
and North Carolina Provider Owned Plans,
Inc. d/b/a My Health By Health Providers,
Respondent-Intervenors.

19 DHR 03352

CERTIFICATE OF SERVICE

The undersigned does hereby certify that a true and correct copy of the foregoing document was uploaded electronically with the Office of Administrative Hearings, causing electronic services, as defined in 26 NCAC 03.0501(4), to be made upon the following:

- Status Report of Aetna Better Health of North Carolina, Inc. d/b/a Aetna Better Health of North Carolina and the North Carolina Department of Health and Human Services

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-and-

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This 4th day of October, 2019

s/ Elizabeth H. Black
Elizabeth H. Black

STATE OF NORTH CAROLINA
COUNTY OF WAKE

IN THE OFFICE OF
ADMINISTRATIVE HEARINGS

<p>Optima Family Care of North Carolina, Inc.,</p> <p>Petitioner,</p> <p>v.</p> <p>North Carolina Department of Health and Human Services, Mandy Cohen M.D., MPH in her official capacity as Secretary of the Department and Dave Richard in his official capacity as Deputy Secretary of the Department of NC Medicaid,</p> <p>Respondents,</p> <p>and</p> <p>WellCare of North Carolina, Inc., Blue Cross and Blue Shield of North Carolina, AmeriHealth Caritas of North Carolina, Inc., Carolina Complete Health, Inc., North Carolina Provider Owned Plans, Inc. d/b/a My Health by Health Providers,</p> <p>Respondent-Intervenors.</p>	<p>19-DHR-01959</p>
<p>North Carolina Provider Owned Plans, Inc. d/b/a My Health by Health Providers,</p> <p>Petitioner,</p> <p>v.</p> <p>North Carolina Department of Health and Human Services,</p> <p>Respondent,</p> <p>and</p> <p>UnitedHealthcare of North Carolina, Inc., Blue Cross and Blue Shield of North Carolina, WellCare of North Carolina, Inc., AmeriHealth Caritas of North Carolina, Inc., Carolina Complete Health, Inc.,</p> <p>Respondent-Intervenors.</p>	<p>19-DHR-02032</p>

<p>Aetna Better Health of North Carolina Inc. d/b/a Aetna Better Health of North Carolina,</p> <p>Petitioner,</p> <p>v.</p> <p>State of North Carolina Department of Health and Human Services,</p> <p>Respondent,</p> <p>and</p> <p>WellCare of North Carolina, Inc., Blue Cross and Blue Shield of North Carolina, AmeriHealth Caritas of North Carolina, Inc., UnitedHealthcare of North Carolina, Inc., Carolina Complete Health, Inc., North Carolina Provider Owned Plans, Inc. d/b/a My Health by Health Providers,</p> <p>Respondent-Intervenors.</p>	<p>19-DHR-02194</p>
<p>Carolina Complete Health, Inc.,</p> <p>Petitioner,</p> <p>v.</p> <p>North Carolina Department of Health and Human Services,</p> <p>Respondent,</p> <p>and</p> <p>North Carolina Provider Owned Plans, Inc. d/b/a My Health by Health Providers,</p> <p>Respondent-Intervenors.</p>	<p>19-DHR-03352</p>

PETITIONER NORTH CAROLINA PROVIDER OWNED PLANS, INC. D/B/A MY HEALTH BY HEALTH PROVIDERS' RESPONSE TO AETNA BETTER HEALTH OF NORTH CAROLINA INC. D/B/A AETNA BETTER HEALTH OF NORTH CAROLINA 'S MOTION AND MEMORANDUM FOR LEAVE TO AMEND ITS PETITION FOR A CONTESTED CASE HEARING

Pursuant to Rule 15 of the North Carolina Rules of Civil Procedure and 26 N.C.A.C. 3.0115, North Carolina Provider Owned Plans, Inc. d/b/a My Health by Health Providers (“My Health”), by and through its undersigned attorneys, responds to Aetna Better Health of North Carolina, Inc.’s (“Aetna”) Motion and Memorandum for Leave to Amend its Petition for a Contested Case Hearing filed with this Tribunal on September 19, 2019. My Health does not oppose Aetna’s motion but files this separate response to note that Aetna’s motion is not procedurally required and the position taken by Respondent and Non-Petitioner-Intervenors has no legal merit. Moreover, and in any event, the serious conflicts of interest and procedural flaws noted in Aetna’s motion have been alleged by My Health in its Verified Petition for Contested Case Hearing and facts learned during discovery that serve as the basis for Aetna’s amendment will be presented to this Tribunal by My Health to support its allegations. Aetna’s amended petition simply provides more details to those violations of the standards of N.C. Gen. Stat. 150B-23(a) and as such its amendment should be allowed since all parties were well aware of these allegations during the entire pendency of the discovery period.

Under N.C. Gen. Stat. §150B-23(a) a petition:

shall state facts tending to establish that the agency named as the respondent has deprived the petitioner of property, has ordered the petitioner to pay a fine or civil penalty, or has otherwise substantially prejudiced the petitioner’s rights and that the agency:

- (1) Exceeded its authority or jurisdiction;
- (2) Acted erroneously;
- (3) Failed to use proper procedure;
- (4) Acted arbitrarily or capriciously; or
- (5) Failed to act as required by law or rule.

Chapter 150B (the “APA”) does not require any form for the pleading or any specificity of the facts required to file a petition. In fact, the Office of Administrative Hearings provides a form that a petitioner may fill out for filing. *See* Ex. A. Many pro se and represented petitioners use this simple, one-page form. The form merely requires the petitioner “[b]riefly state facts showing how you believe you have been harmed by the State agency or board,” state the amount in controversy (if applicable), and check off whether the decision has deprived the petitioner of property; ordered petitioner to pay a fine or civil penalty; or otherwise substantially prejudiced my rights; AND exceeded its authority or jurisdiction; acted erroneously; failed to use proper procedure; acted arbitrarily or capriciously; or failed to act as required by law or rule. *Id.* (emphasis supplied).

In *N.C. Dep’t of Correction v. Hill*, 313 N.C. 481, 329 S.E.2d 377 (1985), the North Carolina Supreme Court rejected a heightened pleading standard for administrative petitions: “The Administrative Procedure Act does not require the particularity of the pleadings of an indictment or a statement of the elements of a cause of action, as required at law or in equity, unless the proceedings are mandatory or penal in nature.” *Id.* at 484–85, 329 S.E.2d at 379. *See also* *Conservative Council of North Carolina v. Haste*, 102 N.C. App. 411, 418, 402 S.E.2d 447, 451 (1991). The APA has not been amended to require a heightened pleading, and these consolidated cases are not mandatory or penal in nature.

In discussing the *Hill* case, OAH’s Chief Administrative Law Judge, Julian Mann, quotes, the Court’s holding that: “The most important characteristic of

pleadings in the administrative process is their unimportance.” Julian Mann, *Striving for Efficiency in Administrative Litigation: North Carolina’s Office of Administrative Hearings*, 15 J. Nat’l Ass’n Admin. L. Judges 151, 163 n.50 (1995) (citing *See Correction v. Hill*, 313 N.C. at 484, 329 S.E.2d at 379). Therefore, all that the APA requires is facts showing harm and violation of the APA.

While Aetna’s motion to amend the petition is permissible under the North Carolina Rules of Civil Procedure, it is not necessary for Aetna or any other Petitioner to make such amendments to their petitions for contested case hearing to pursue additional theories for why the Agency violated the standards of the APA. In ruling on Aetna’s motion, this Tribunal should decline to adopt the overly formalistic approach put forth by the Respondent and the Non-Petitioner Intervenor. Adopting their approach would set a precedent that would not only harm Aetna but also Petitioners in other cases, many of whom pursue contested cases without the benefit of counsel. For example, under the approach supported by Respondent-Intervenor Blue Cross and others, a Petitioner could uncover damaging facts against an Agency that were not known to it during an informal agency reconsideration hearing, which take place prior to discovery, and would be unable to pursue such facts, because it “failed to exhaust administrative remedies” by not raising those facts during the reconsideration review. Such an approach would be patently unfair and would encourage the Department to hide facts until after the informal reconsideration is complete and a petition for contested case is filed. It would also force a Petitioner to make allegations in reconsideration requests for

which it does not have facts to support, due to the lack of formal discovery in such reviews.

Even setting aside the problems with the exhaustion of administrative remedies argument, forcing a Petitioner to amend its contested case petition to include facts and allegations developed during discovery would undermine the use of the existing OAH forms, which require very little in terms of setting forth specific claims. OAH has not typically held Petitioners to such a standard and it has always been OAH's practice during its long history to allow Petitioners to present evidence that N.C. Gen. Stat. § 150B-23(a) was violated based on the evidence developed during discovery in the contested case. Establishing a new practice that requires a Petitioner to amend its petition to pursue additional claims developed during the contested case would serve as a powerful tool for any state agency subject to OAH's jurisdiction to avoid claims pursued by a less sophisticated Petitioner. As this Tribunal is well aware a large number of cases brought before OAH are litigated by individuals affected by agency decisions who do not have counsel or the vast resources of the State. Thus requiring Petitioners to adopt the overly formalistic practices of courts of general jurisdiction to amend petitions would serve to undermine the informal pleading requirements that have historically been embraced by this Tribunal. My Health urges this Tribunal not to create a "pleading with particularity" requirement into the APA that simply does not exist.

Regardless of how this Tribunal rules on Aetna's motion, My Health has already set forth allegations in its petition consistent with the facts set forth in

Aetna's Amended Contested Case Petition. For example, My Health's Verified Petition states:

On information and belief, the Department's design of the RFP was also flawed because it used private consultants, many of whom have long histories working with commercial plans as their clients. The Department allowed these consultants' bias towards commercial plans and lack of provider-led entity experience to infiltrate the design of the RFP.

The Department did more than just allow this bias to seep through the process—the Department invited it. In seeking a comprehensive program design and support contract, the Department did not seek an entity experienced in designing procurements for provider-led organizations as intended by the legislation. In the Department's request to contract with its consulting firm, the term "provider-led entity" was used only once, in the background section describing the legislative mandate. The term "provider-led entity" was not used in the evaluation criteria or in the major tasks established in the contract.

...

The Evaluation Committee was made up exclusively of Department employees who appear to lack sufficient experience to evaluate the RFP responses and make the contract award recommendations. For example, not a single licensed health care provider was included in the Evaluation Committee. None of them appear to have been involved in Medicaid managed care in any states that have provider-led managed care.

...

The Evaluation Committee relied heavily on "Subject Matter Experts" and other non-scoring attendees. The Subject Matter Experts and other non-scoring attendees were individuals that were asked to advise the Evaluation Committee on numerous topics. Although the role of Subject Matter Experts is not formally defined in procurement documents, the frequent reference to these individuals in the Evaluation Committee minutes suggests significant influence over the evaluation process.

These Subject Matter Experts and other non-scoring attendees included individuals who had recent and substantive experience working with and even employed by commercial plans—the same ones that they were evaluating. For example:

a. Jay Ludlam, Assistant Secretary for Medicaid Transformation was considered to be part of the “non-scoring leadership” despite his recent prior work for WellCare, one of the winning commercial plans.

b. Lotta Crabtree, who served as the Evaluation Committee’s Legal Counsel, recently worked for the North Carolina State Health Plan, which is administered by BCBS, one of the winning commercial plans.

c. Sarah Gregosky, a Subject Matter Expert, recently worked for BCBS, one of the winning commercial plans.

Upon information and belief, these and other individuals’ conflicts of interest were not properly vetted. They had significant influence over the evaluation process, injecting favoritism towards commercial plans throughout the evaluation process.

Based on the limited procurement documents that the Department has provided to date and DHB’s defense at the bid protest meeting, it is exceedingly clear that the evaluation process was biased, erroneous, arbitrary and capricious, and unlawful.

Verified Pet. ¶¶ 45–46, 62, 66–69. My Health also specifically reserved the ability to develop its arguments through discovery: “Because the Department has not produced all of the requested documents pursuant to public records requests, My Health specifically reserves the ability to further develop these arguments in discovery.” *Id.* ¶¶ 59, 99. Accordingly, this Tribunal’s ruling on Aetna’s motion

would not in any way impact My Health's ability to proceed on the issues in its contested case and would not limit this Tribunal's ability to issue a Final Agency Decision on the facts alleged by Aetna in its Amended Contested Case Petition. Moreover, the fact that My Health made such allegations in its petition makes any argument by Respondent and Non-Petitioner Intervenors that they did not have an opportunity to pursue discovery as to the allegations in Aetna's Amended Complaint patently false because these allegations were largely set forth in My Health's Petition.

Given that the issues described in Aetna's Amended Petition will be considered by the Court in My Health's contested case, this Court should grant Aetna's Motion to Amend Its Petition. Alternatively this Tribunal could determine that Aetna's Motion is unnecessary for it to pursue the claims set forth in its Amended Petition.

This 4th day of October 2019.

/s/ Matthew W. Wolfe

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CERTIFICATE OF SERVICE

The undersigned certifies that, on the date shown below, I served the foregoing document upon all counsel of record by electronic mail:

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This the 4th day of October 2019.

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EXHIBIT A

PLEASE PRINT CLEARLY OR TYPE

STATE OF NORTH CAROLINA

IN THE OFFICE OF
ADMINISTRATIVE HEARINGS

COUNTY OF (1) _____

(2) _____)
_____)
_____)
(your name) PETITIONER,)
_____)
v.)
_____)
(3) _____)
_____)
_____)
RESPONDENT.)
(The State agency or board about which you are complaining))

**PETITION
FOR A
CONTESTED CASE HEARING**

I hereby ask for a contested case hearing as provided for by North Carolina General Statute § 150B-23 because the Respondent has:

(Briefly state facts showing how you believe you have been harmed by the State agency or board.)

(4) Amount in controversy \$ _____ (if applicable)

(If more space is needed, attach additional pages.)

(5) Because of these facts, the State agency or board has: (check at least one from each column)

_____deprived me of property;		_____exceeded its authority or jurisdiction;
_____ordered me to pay a fine or civil penalty; or		_____acted erroneously;
_____otherwise substantially prejudiced my rights;	AND	_____failed to use proper procedure;
		_____acted arbitrarily or capriciously; or
		_____failed to act as required by law or rule.

(6) Date: _____ (7) Your phone number: () _____

(8) Print your full address: _____

(street address/p.o. box)

(city)

(state)

(zip)

(9) Print your name: _____

(10) Your signature: _____

You must mail or deliver a **COPY** of this Petition to the State agency or board named on line (3) of this form. You should contact the agency or board to determine the name of the person to be served.

CERTIFICATE OF SERVICE

I certify that this Petition has been served on the State agency or board named below by depositing a copy of it with the United States Postal Service with sufficient postage affixed **OR** by delivering it to the named agency or board:

(11) _____ (12) _____
(name of person served) (State agency or board listed on line 3)

(13) _____
(street address/p.o. box) (city) (state) (zip code)

(14) This the _____ day of _____, 20____.

(15) _____
(your signature)

When you have completed this form, you **MUST** mail or deliver the **ORIGINAL** to the Office of Administrative Hearings, 6714 Mail Service Center, Raleigh, NC 27699-6700.

This box for OAH use only.

Amount Paid \$_____

☐ Cash – receipt number _____

☐ Money Order ☐ Certified Check ☐ Attorney Trust Account

Check number_____

☐ Indigent (must complete form HOI)

☐ Mandated federal cause of action

Received by:_____

INSTRUCTIONS FOR FORM H-06
“PETITION FOR A CONTESTED CASE” AND “CERTIFICATE OF SERVICE”

FILL IN BLANKS:

Fill in your county of residence (1), print your name on line (2), and the name of the agency or board about which you are complaining on line (3). Be sure to briefly state the facts about your case. Enter the dollar amount in controversy, if applicable on line (4). Check all of the items that apply in section (5). Enter the date on line (6), your telephone number on line (7), your address on line (8), print your name on line (9), and **sign your name on line (10)**.

CERTIFICATE OF SERVICE:

You must mail or deliver a copy of your completed petition to the agency or board named on line (3) and complete the “certificate of service” section on your petition, entering the name of the person to whom you mailed or delivered the petition on line (11). You should contact the agency or board to determine the name of the person to be served. Print the name of the state agency involved on line (12), the address of the agency or board on line (13), the date on line (14), and **sign your name on line (15)**.

FILING FEE

Filing fees can be paid by either, cash, money order, certified check or checks drawn on attorney trust accounts. The fee must be paid at the time the petition is filed. Checks should be made payable to the Office of Administrative Hearings. If your case is involving a mandated federal cause of action there is no fee. The filing fee for Certificate of Need cases is \$125.00 as well as Environmental issues concerning Clean Water Act permitting, Clean Air Act permitting, Animal Waste Management System permitting, and permitting for water use within capacity use areas and any case when the amount in controversy is \$50,000.00 or more. All other case types shall pay \$20.00.

FILING YOUR PETITION WITH THE OFFICE OF ADMINISTRATIVE HEARINGS:

Your contested case will commence as soon as you file your completed original petition, properly signed and appropriate fee paid, with the Office of Administrative Hearings. Below are the mailing and physical addresses:

Office of Administrative Hearings
6714 Mail Service Center
Raleigh, NC 27699-6700

Office of Administrative Hearings
1711 New Hope Church Road
Raleigh, NC 27609-6285

If you mail this form, the case commences when it is **received and filed** in this office.

You may file your petition by fax during normal business hours by faxing the petition to the Clerk's Office at (919) 431-3100.

You may file your petition by electronic mail by an attached file either in PDF format or a document that is compatible with or convertible to the most recent version of Word for Windows by sending the electronic transmission to oah.clerks@oah.nc.gov. Electronic mail without attached file shall not constitute a valid filing.